

Kingston and Richmond LSCB

BRUISING IN PRE-MOBILE BABIES AND NON-MOBILE CHILDREN WITH DISABILITIES

A PROTOCOL FOR ASSESSMENT, MANAGEMENT AND REFERRAL BY PROFESSIONALS

1.0 Introduction:

- 1.1 Bruising is the commonest presenting feature of physical abuse in children. The younger the child, the higher the risk that bruising is non-accidental, especially where the child is under the age of 6 months (see Cardiff Child Protection Systematic Reviews <http://www.core-info.cardiff.ac.uk/reviews/bruising>).
- 1.2 NICE guidance When to Suspect Child Maltreatment <http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English> (Clinical Guideline 89, July 2009) states that bruising in any child 'not independently mobile' should prompt suspicion of maltreatment.
- 1.3 A non-independently mobile or pre-mobile infant is a baby who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. This includes all babies under the age of 6 months.
- 1.4 Recent serious case reviews and individual child protection cases both nationally and locally have indicated that those who work or volunteer with children and their wider families have sometimes underestimated the potential significance of bruising in pre-mobile babies. Babies with bruising have been found to have multiple other injuries on further investigation or have presented again later with more serious injuries, including inflicted brain injury. Any bruising is likely to come from external sources and should raise child protection concerns.
- 1.5 In the past, advice to frontline professionals was that a referral to Children's Services should be made if bruising in babies was not plausibly explained. However, in light of the increasing evidence base and learning from case reviews, advice to frontline professionals has changed and is necessarily directive.
- 1.6 Bruising in any pre-mobile infant should prompt an immediate referral to Children's Services via the Single Point of Access (SPA) in Kingston or

Richmond, who will arrange an urgent medical assessment by a senior paediatrician.

- 1.7 Innocent bruising in pre-mobile infants is rare. It is the responsibility of the strategy group members undertaking a Section 47 child protection investigation to decide whether bruising is consistent with an innocent cause or not.
- 1.8 Whilst this protocol recognises that professional judgment and responsibility have to be exercised at all times, it errs on the side of safety by requiring that all pre-mobile babies with bruising be referred to Children's Social Care via the SPA (Single Point of Access) and for a senior paediatric opinion where there is no obvious medical cause.

KEY MESSAGES:

- **Bruising is the most common presenting feature in physical abuse in children.**
- **The younger the child, the higher the risk that the bruising is non-accidental, especially where the child is under the age of 6 months.**
- **Bruising in any child 'not independently mobile' should prompt suspicion of maltreatment.**
- **Bruising in any pre mobile baby should prompt an immediate referral to Children Social Care via the SPA, who will arrange an urgent medical examination by a senior paediatrician.**

- 1.9 Infants who have yet to acquire independent mobility (rolling/crawling) should not have bruises without a clear explanation. Numerous learning and improvement case reviews, both locally and nationally, have identified the need for heightened concern about any bruising in any pre-mobile baby. Any bruising is likely to come from external sources and should raise child protection concerns.

2.0 AIM OF PROTOCOL

- 2.1 The aim of this agreed multi-agency protocol is to provide frontline Children Social Care, Health and other professionals with a knowledge base and action strategy for the assessment, management and referral of pre-mobile babies who present with bruising or otherwise suspicious marks.
- 2.2 This protocol must be followed in all situations where an actual or suspected injury is noted in an infant, who is not independently mobile.

2.3 This policy applies to all infants under the age of 6 months, and also to older children up to age 2 years who are not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently.

2.4 This protocol focuses on bruising in pre-mobile babies.

2.5 The information in this protocol is also relevant to older children who are not independently mobile, by reason of disability. Bruising in any child 'not independently mobile' should prompt suspicion of maltreatment. If in any doubt, professionals should discuss the case further.

3.0 TARGET AUDIENCE

3.1 All professionals and volunteers who may come across bruising to pre-mobile babies or non-mobile children with disabilities.

4.0 DEFINITIONS

4.1 Pre-mobile baby: A baby who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. This includes all babies under the age of six months.

4.2 Bruising: Extravasation of blood in the soft tissues, producing a temporary, non-blanching discolouration of skin however faint or small with or without other skin abrasions or marks. Colouring may vary from yellow through green to brown or purple. This includes petechiae, which are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

5.0 CHILDREN WITH A DISABILITY

5.1 Consideration should be given to applying this protocol to older children who are not independently mobile by reason of a disability. If in any doubt, professionals should discuss with their safeguarding lead and ring the Single Point of Access (SPA).

6.0 SCOPE OF THE PROTOCOL

6.1 Any bruising, or what is believed to be bruising, in a child of any age that is observed by, or brought to the attention of any professional or volunteer should be taken as a matter for inquiry and concern. This protocol relates only to bruising in pre-mobile babies, that is to say babies who are not yet crawling, shuffling, pulling to stand, cruising or walking independently.

6.2 It is not always easy to identify with certainty a skin mark as a bruise. Practitioners should take action in line with this protocol if they believe that there is a possibility that the observed skin mark could be a bruise or could be the result of injury or trauma.

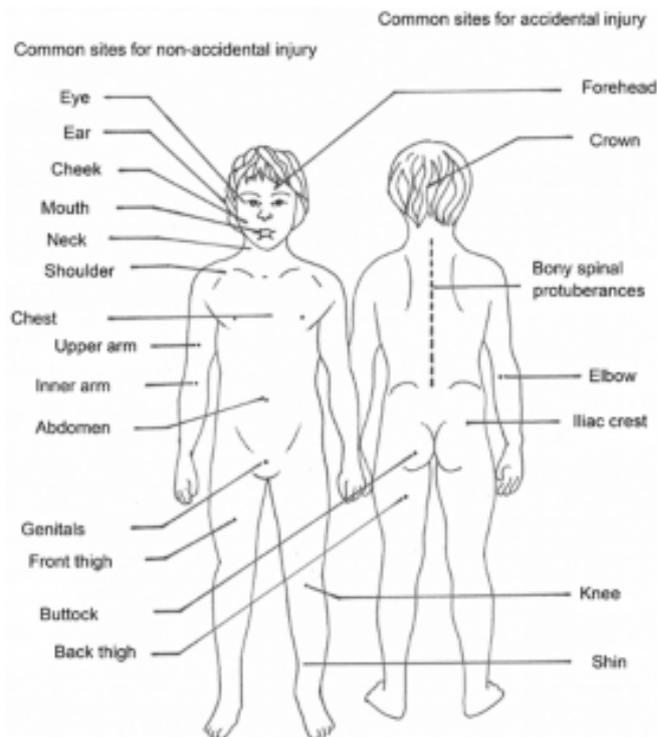
- 6.3 It is accepted that marks could be the result of birth trauma, birth marks or areas of skin pigmentation such as 'Mongolian Blue Spots'. However, if there is any doubt as to the nature of the mark caution should be exercised and this protocol should be followed.
- 6.4 While accidental and innocent bruising is significantly more common in older mobile children, professionals are reminded that mobile children who are abused may also present with bruising (Baby Peter, 2008). They should seek a satisfactory explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history, to ensure that it is consistent with an innocent explanation.
- 6.5 Immobility, for example due to disability, in older children should particularly be taken into account as a risk factor. Disabled children have a higher incidence of abuse whether mobile or not. (Ofsted 2011 Protecting Disabled Children -a thematic inspection).

7.0 RESEARCH BASE

- 7.1 There is a substantial and well-founded research base on the significance of bruising in children. See:

http://www.nspcc.org.uk/inform/research/findings/bruisesonchildren_wda_48_277.html

- 7.2 Although bruising is not uncommon in older, mobile children, it is rare in infants that are immobile, particularly those under the age of six months. While up to 60% of older children who are walking have bruising, it is found in less than 1% of 'not independently mobile' infants. Bruising in older mobile children can also be non accidental.



7.3 Research undertaken in Wales indicates that severe child abuse is six times more common in babies aged under one year, than in children aged one to 4 years, and 120 times more likely than in the 5 – 13 year old age group. This research also showed that, of the abused babies aged under one year, 30% had caused previous concern to health professionals in relation to abuse or neglect.

7.4 Further research into child deaths from non-accidental injuries and children who suffer serious injury suggests that these children often have a history of minor injuries prior to hospital admission.

7.5 On average, the under ones are seven times more likely to be killed than older children in England and Wales (NSPCC, March 2013) See: http://www.nspcc.org.uk/Inform/research/statistics/child_homicide_statistics_wda_48747.html)

8.0 EMERGENCY ADMISSION TO HOSPITAL

8.1 Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be referred immediately to hospital.

8.2 Occasionally spontaneous bruising may occur as a result of a medication condition such as a bleeding disorder, thrombocytopenia or meningococcal or other acute infection. Child protection issues should not delay the referral of a seriously ill child to acute paediatric services.

8.3 A referral to hospital under the above circumstance should not be delayed by a referral to Children's Social Care, which, if necessary, should be undertaken from the hospital setting. However, it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Social Care has been made.

8.4 It should be noted that children may be abused (including sustaining fractures, serious head injuries and intra-abdominal injuries) with no evidence of bruising or external injury.

9.0 REFERRAL TO CHILDREN'S SOCIAL CARE

9.1 The presence of any bruising in pre-mobile babies of any size, in any site, should initiate a detailed examination and inquiry into its explanation, origin, characteristics and history. The child should then be referred to Children Social Care via the SPA. Never delay emergency action to protect a child.

9.2 Where a decision to refer is made, it is the responsibility of the first professional to learn of or observe the bruising to make the referral.

9.3 The decision to refer may be undertaken jointly with another professional or senior colleague. However this discussion should not delay an individual professional of any status referring to Children's Services any child with bruising who, in their judgement, may be at risk of child abuse.

9.4 An individual practitioner must not be afraid to challenge the opinion of a colleague if they believe in their own judgement that a child might be at risk of harm, especially a very young child who will be particularly vulnerable.

9.5 Children's Social Care (CSC) will take any referral made under this protocol as requiring further multi-agency investigation. CSC will initiate Section 47 multi agency Child Protection Enquiries, if needed and will involve all appropriate agencies such as police, health providers, as per protocol. All cases where a pre-mobile child has sustained bruises will be subject to the Multi Agency Safeguarding Hub (MASH) screening process. CSC will contact the Paediatrician to whom referral is also made for a medical opinion before reaching any final conclusions on the case.

9.6 All telephone referrals must be followed up within 48 hours with a written referral. All referrals will be acknowledged and the referrer notified of next steps within 24 hours of the referral being made to the SPA.

10.0 REFERRAL FOR A PAEDIATRIC OPINION BY SOCIAL CARE

10.1 Once a referral has been made to the SPA, Children's Social Care will take responsibility for making a referral to the paediatric services.

- 10.2 The referral should be made, and the child seen, on an urgent and immediate basis. Wherever possible, a member of staff from Children's Services should accompany the family at the assessment.
- 10.3 The relevant paediatrician must liaise with Children's Social Care with regard to the outcome of the assessment as soon as it is completed.
- 10.4 Where a referral is delayed for any reason, or where bruising is no longer visible, a senior paediatrician must still examine the child to assess, as a minimum, general health, signs of other injuries or pointers to maltreatment, and to exclude bleeding disorders.

11.0 INNOCENT BRUISING

- 11.1 It is recognised that a small percentage of bruising in pre-mobile babies will have an innocent explanation (including medical causes). Nevertheless, because of the difficulty in excluding non-accidental injury, practitioners should refer to Children's Social Care.
- 11.2 It is the responsibility of Children's Social Care, in conjunction with the local acute or community paediatric department, and other agencies involved with the family to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not.
- 11.3 The pattern, number and distribution of innocent bruising in non-abused children is different to that in those who have been abused. Innocent bruises are more commonly found over bony prominences and on the front of the body, but rarely on the back, buttocks, abdomen, upper limbs or soft-tissue areas such as cheeks, around the eyes, ears, palms or soles. One would not expect such 'innocent' bruising in pre-mobile babies.
- 11.4 In general practice, any history of bruising should be flagged as a significant problem/risk factor in the notes.

12.0 ASSESSMENT AND RISK

- 12.1 A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. A full clinical examination and relevant investigations must be undertaken.
- 12.2 The younger the child, the greater the risk that bruising is non-accidental and the greater the potential risk to the child.
- 12.3 Bruising which might be indicative of abuse include:
- **Bruising on the head, especially the face, ears and neck**

- **Multiple bruising, especially of uniform shape or symmetrical positions**
- **Bruises in clusters**
- **Large bruises**
- **Bruising on soft tissues (away from bony prominences) especially cheeks and around eyes**
- **Bruising on the abdomen, upper limbs (especially arms and hands), buttocks and back**
- **Bruising around the anus or genitals**
- **Imprints and patterns, including fingertip bruising, hands, rods, ropes, ligatures, belts and buckles**
- **Bruising caused by an object or implement may not always show a typical imprint of the injuring object in some areas of the body, such as the cleft of the buttocks and the ears**
- **Petechiae**
- **A boggy forehead swelling with peri-orbital oedema (caused by violent pulling of the child's hair)**
- **Accompanying injuries such as scars, scratches, abrasions, burns or scalds**
- **Bruising in children with a disability**

13.0 DOCUMENTATION

- 13.1 The importance of signed, timed, accurate comprehensive contemporaneous records cannot be over-emphasised.
- 13.2 As part of the paediatric assessment, it is good practice to photograph any visible injuries. Ideally these photographs will be taken by the medical photography department following a request by the clinician expert.
- 13.3 The history and examination will be undertaken and the paediatrician will give an opinion about the injury. Further medical investigations may be required. It may be necessary to admit an infant to hospital whilst the investigations are completed. Where bruising is unexplained and/or raises significant concern about non-accidental injury a safety plan will be put into place by Children's Services ensuring supervision of the infant whilst the medical investigations and assessments by other agencies are carried out. Other siblings in the family should be considered at the same time, to assess if they face any risk and if they require medical examination.

14.0 WORKING IN PARTNERSHIP WITH PARENTS OR CARERS

- 14.1 Unless it is considered that this would place the child at further risk, the professional's concerns should be discussed with parents or carers of the child at the time they arise/occur, taking care that the professional does not suggest to the parents/carers how the injury has occurred.

- 14.2 The child's parents or carers should be informed of any intention to make a referral to Children's Social Care – unless it is considered that this would place the child at further risk.
- 14.3 If the child's parents/carers are not aware of the referral, this must be made clear to Children's Social Care.
- 14.4 If a parent or carer is uncooperative or refuses to take the child for further assessment, this must be reported to Children's Social Care. If possible, the child should be kept under supervision until steps can be taken to secure his or her safety.

15.0 CONFIDENTIALITY

- 15.1 Whenever possible, the child's parent or carer should be informed before sharing confidential information. However, if this would incur delay, or if to do so would put the child or the professional at risk, then practitioners can be reassured that confidential information may be lawfully shared if it can be justified in the public interest (Information Sharing: Guidance for Practitioners and Managers HM Government 2008). 'The public interest' includes the belief that a child maybe suffering, or be at risk of suffering, significant harm. (Working Together to Safeguard Children 2015).
- 15.2 If a parent or carer is uncooperative or refuses to take the child for further assessment or investigation, this should be reported immediately to Children's Social Care. If possible the child should be kept under supervision until steps can be taken to secure his or her safety.

16.0 THE WELFARE OF THE CHILD IS PARAMOUNT (Children Act 1989)

- 16.1 The Child's welfare is paramount and safeguarding and promoting it is the priority. Lord Justice Elizabeth Butler-Sloss in the Court of Appeal stated that where there is a conflict of interest between the rights and interests of a child and those of a parent, the interests of the child had to prevail under Article 8 (2) of the European Union.

16.2 Consent for Paediatric Assessment/Medical Treatment

- 16.2.1 The following may give consent to a paediatric assessment:

- A young person of 16 and over;
- A child of under 16 where a doctor considers he or she is of sufficient age and understanding to give informed consent and is "Fraser Competent";
- Any person with Parental Responsibility;

- The local authority when the child is the subject of a Care Order (although the parent/carer should be informed);
 - The local authority when the child is Accommodated and the parent/carers have abandoned the child or are physically or mentally unable to give such authority; If a child needs urgent medical attention do not delay call 999
 - The High Court when the child is a Ward of Court;
 - A Court as part of a direction attached to an Emergency Protection Order, an Interim Care Order or a Child Assessment Order.
- 16.2.2 Where the child is the subject of ongoing Court proceedings, legal advice should be obtained about obtaining the Court's permission to the paediatric assessment. It is generally good practice to seek wherever possible the permission of a parent for children under 16 prior to any paediatric assessment and/or other medical treatment even if the child is judged to be of sufficient understanding to give consent in their own right. If this is not considered possible or appropriate, then the reasons should be clearly recorded.
- 16.2.3 When a child is Looked After and a parent/carer has given general consent authorising medical treatment for the child, legal advice must be taken about whether this provides consent for a paediatric assessment for child protection purposes (the parent/carer still has full parental responsibility for the child).
- 16.2.4 Where the local authority shares Parental Responsibility for the child, the local authority must also consent to the paediatric assessment.
- 16.2.5 A child who is of sufficient understanding may refuse some or all of the paediatric assessment, although refusal can potentially be overridden by a court.
- 16.2.6 In emergency situations where the child needs urgent medical treatment and there is insufficient time to obtain parental consent:
- The medical practitioner may decide to proceed without consent; and/or
 - The medical practitioner may regard the child to be of an age and level of understanding to give her/his own consent and be Fraser Competent. In these circumstances, parents must be informed as soon as possible and a full record must be made at the time. In non-emergency situations, when parental permission is not obtained, the social worker and manager must seek legal advice.

16.2.7 For additional guidance to doctors, see the Protecting Children and Young People - the Responsibilities of all Doctors' (GMC 2012).