Merton Safeguarding Children Board Multi-Agency Guidance on Bruising In Non-Independently Mobile Infants and Children

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Contents

1. Introduction

This guidance is designed to support professionals' practice in the assessment and management of bruising in non-independently mobile infants (usually under 6 months). The aims of the guidance are to:

- Outline pathways in Merton for the referral and assessment of bruising in non-independently infants and children.
- Ensure that all partners are responding to bruising in non-independently mobile infants and children in a consistent way.
- Support practitioners to effectively respond to concerns about non –accidental injury in non-independently mobile infants and children

2. Definition

The following definitions are applied for the purpose of this guidance:

Not Independently Mobile (NIM): is an infant who is not yet crawling, bottom shuffling, or cruising. It includes **all** infants under 6 months. This includes children with a disability or a condition which means that they are not independently mobile.

Bruising is defined as: Extravasations 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 or red. This includes petechiae, which are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

3. Literature review

There is a substantial and well-founded research base on the significance of bruising in children. See the **Core Info website** and also a national repository of Serious Case Reviews at NSPCC serious-case-reviews which provides a national picture of concerns.

The Research base demonstrates that bruising in Not Independently Mobile infants is very rare; **particularly those under the age of six months**. The implication for practice is that the younger the baby the greater is the risk that bruising is non-accidental.

Patterns of bruising suggestive of physical child abuse include:

- Bruising in children who are Not Independently Mobile, particularly those < 6 months of age;
- Bruises that are away from bony prominences;
- Bruises to the face, back, abdomen, arms, upper thighs, buttocks, ears and hands;
- Multiple or clustered bruising;
- Imprinting and petechiae;
- Symmetrical bruising.

A bruise whatever its size 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.

Body maps to record bruising should be completed in all cases where there are concerns about non accidental injury. This is to address the potential for inaccurate recording when there are multiple bruises / patterns of bruising over time, as identified in both national and local Serious Case Reviews.

A recent analysis undertaken by the Social Care Institute of Excellence (SCIE) (2016) of SCR reports highlights a number of reasons for failing to make a referral to CSC in response to bruising in non-mobile babies including:

- a lack of understanding of child protection procedures, particularly among those working in out of hours GP surgeries
- a lack of professional curiosity and 'respectful scepticism' about explanations for bruising
- second opinions not sought from more experienced clinicians.

SCIE also identified the following underlying reasons for the failure to make referrals:

1) A lack of knowledge about the NICE guideline which recommends referral following bruising to non-mobile babies.

2) That vulnerable families are more likely to use out of hours services, but conversely these were less likely to have safeguarding expertise and knowledge of local systems, and were also less likely to build sustained relationships with families which would support them.

3) Influence of the relationship with the family; the problem of questioning explanations, particularly from families who seem 'plausible', or are professionals themselves.[1]

4. Scope

This guidance relates only to bruising in children who are not yet independently mobile as stated previously. While accidental and innocent bruising is significantly more common in older mobile children, practitioners are reminded that mobile children who are abused may also present with bruising.

It should also be noted that all children may be abused and have no evidence of bruising or external injury for example fractures, serious head injuries and intra-abdominal injuries.

5. Guidance

The following guidance is taken from the clinical guidance summary issued by the National Institute for Clinical Excellence (NICE) '*When to suspect child maltreatment in under 16's.* It is aimed at health professionals, categorises features that should lead staff to 'consider abuse' as part of a differential

[1] Learning into practice: improving the quality and use of Serious Case Reviews , *Practice issues from Serious Case Reviews, 3. Not making a referral after bruising to non-mobile babies,* (2016) p 1. SCIE and NSPCC

diagnosis, or 'suspect abuse' such that there is a serious level of concern. The Social Care Institute for Excellence (SCIE) refer to the NICE guidance in inter-professional communication and the role of the LSCB referral and assessment procedures to ensure that cases are referred to children's social care.

The NICE guidance[2] sets out that, practitioners should seek an explanation for all bruising and assess its characteristics and distribution to seek assurance that it is consistent with the parent or carer's explanation. All discussions should be recorded and where possible the explanation recorded

In relation to bruising, health professionals are advised to 'suspect abuse' and refer to children's services in the following situations:

a) If a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

b) If there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable. Examples include:

- bruising in a child who is not independently mobile
- multiple bruises or bruises in clusters
- bruises of a similar shape and size
- bruises on any non-bony part of the body or face including the eyes, ears and buttocks
- bruises on the neck that look like attempted strangulation
- bruises on the ankles and wrists that look like ligature marks.
- Ear Bruising[3]

The NICE guideline also advises practitioners to 'suspect abuse' when features of injury such as bites, lacerations, abrasions, scars and thermal injuries are seen on a child who are not independently mobile and there is an unsuitable explanation.

6. Guidance for specific circumstances

There are specific circumstances to take into account which covers the following:

Birth injury: both normal births and instrumental delivery may lead to development of bruising and of minor bleeding into the white of the eye. However, staff should be alert to the possibility of physical abuse within a hospital setting and follow this protocol if there is any doubt about the origin of the features seen. Professionals should record any injuries on a body map and ensure the Parent Held Child Record (PHCR) is updated with information by obstetric and midwifery services.

Birthmarks: these may not be present at birth, and appear during the early weeks and months of life. Certain birthmarks, particularly Mongolian blue spots (congenital dermal melanocytosis), can

[2] NICE Guidelines (2009), *Child Maltreatment: When to Suspect Maltreatment in Under 18s* (CG89), p 12, https://www.nice.org.uk/guidance/cg89/resources/child-maltreatment-when-to-suspect-maltreatment-in-under-18s-pdf-975697287109
[3] ibid

mimic bruising. Where there is uncertainty about the nature of a mark, the infant should be discussed with the primary care team in the first instance. Birth marks should also be recorded in the child's health record and the PHCR.

Self-inflicted injury: It is exceptionally rare for non-mobile infants to injure themselves during normal activity. Suggestions that a bruise has been caused by the infant hitting him/herself with a toy, falling on a dummy or banging against an adult's body should not be accepted without detailed assessment by a paediatrician and social worker

Injury from other children: it is unusual but not unknown for siblings to injure a baby. In these circumstances, the infant must still be referred for further assessment, which must include a detailed history of the circumstances of the injury, and consideration of the parents' ability to supervise their children.

7. Action to be taken on identifying actual or suspected bruising

Parents and carers should be included in the decision to refer provided this does not pose a further risk to the child. Information about the referral should also be shared with the child's GP and health visitor/school nurse and this information sharing should be recorded in records as per the agencies record keeping policy.

If the infant appears seriously ill or injured;

- Seek emergency treatment at an emergency department.
- Notify children's services of your concerns and the child's location.

In all other cases;

- Record what is seen, using a body map or line drawing if appropriate (Appendix 2).
- Record any explanation or other comments by the parent/carer word for word.
- Inform parents/carers of your professional responsibility to follow safeguarding children policies and procedures and stress that any action by children's social care will be informed by a paediatrician's opinion,
- Refer to MASH as first point of contact who will take responsibility for further multi-agency investigation

Action following referral

- Children's social care will follow the London Child Protection procedures and apply the MSCB threshold guidance for referral and assessments. This will include gathering background information about the family and arranging a medical opinion.
- The child must be seen on the day of referral for full paediatric assessment. This must include a detailed history from the carer, review of past medical history and family history including any previous reports of bruising, and enquiry about vulnerabilities within the family.
- Parents should not be given the responsibility of making arrangements to seek medical advice themselves and where possible the lead professional for the investigation should

ensure that they are present and/or have shared information with and spoken to the clinician who is seeing the child.

8. Referral for Child Protection Medical examination by Paediatrician

The referral for a child protection medical examination involved completing the referral form available in appendix 1 of this guidance. Here are the contact details:

- Please contact Community Paediatric CP admin on first then forward the completed form via a secure email to to**.** *Email is preferred than fax so that we can also continue typing into the same form in the relevant sections.*

- Office hours for CP admin: **0900 -1700 hours Mon-Fri**

- CP medicals by Community Paediatrician takes place between **0900 and 1600 hours Mon-Fri**

- If 'Out of Hours', please contact the on call Paediatric Registrar via hospital switchboard on and ask for bleep number: 197.

Please note, the fact that a CP Medical is unable to be definitive regarding the cause of a bruise or injury should not be a barrier to effective intervention to protect children.

9. References

Core Info Cardiff Child Protection Systematic Reviews www.coreinfo.cardiff.ac.uk

The National Institute for Clinical Excellence (NICE) (2009) *Child maltreatment: when to suspect maltreatment in under 16s* http://www.nice.org.uk/guidance/cg89

NSPCC National Repository of Serious Case Reviews https://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/serious-case-reviews/

Social Care Institute for Excellence and NSPCC (2016) Learning into practice: improving the quality and use of Serious Case Reviews , *Practice issues from Serious Case Reviews, 3. Not making a referral after bruising to non-mobile babies,*

Appendix 1

Request for Child Protection Medical

[One form per child please]

- *Please make a telephone call to our CP admin on* 020 8296 4854 *prior to sending this form by email or fax to make sure the safe and on time receipt.*

- *Please type direct into the form if possible – this is MS Word template and each space in the form is expandable if required.*

Social Worker to complete all elements of first section:

Type of referral (Underline or place x as appropriate)	Physical	Neglect	Emotional	Sexual
Urgency of Medical (Underline or place x as appropriate)	Urgent		Non-urgent	
Social Services Team (Underline or place x as appropriate)	Merton		Sutton	
Name of Social Worker				
SW Office and Mob Nos				
Date and time of referral				
Name of child				
Date of Birth				
Full Address:				
Tel No				
Name, address and tel no of GP (if known)				
Name of School / Nursery				
Name and contact number for school nurse / HV (if known)				
Who has parental responsibility?				
Has consent been obtained for medical? (Underline or place x as appropriate)	Yes No If yes, from Whom:			
Who is accompanying this child?	Name: Relation to child:			

Do you think they will present any safety risk to the staff that we need to be aware of? (Underline or place x as appropriate)	Yes No Details (if Yes):	
Who will provide medical history?		
Is interpreter required? (Underline or place x as appropriate)	Yes No	If yes, what language:
Any previous SS involvement? * (Underline as appropriate)	Yes No If yes, give details in the "Detailed account of circumstances.." section bellow	
Subject to CPP (Underline or place x as appropriate)	Yes No	
Subject to CINP: (Underline or place x as appropriate)	Yes No	
Any other agency involved? (Underline or place x as appropriate)	Yes No Details:	
Any known medical conditions/developmental /behavioural issues: (give details if yes)		
Has the child been seen by SW? (Underline as appropriate)	Yes, No, If yes, give details in the "Detailed account of circumstances.." section bellow	
Has the child/family seen by CAIT? (Underline or place x as appropriate)	Yes, No Details(including name and contact detail of the police officer, if ABE is done or planned for):	
Any Court order? (Underline or place x as appropriate)	Yes, No Details :	
Have arrangements been made for a safe place for the child if needed? (Underline or place x as appropriate) Do not wait for the result of medical	Yes No Detail:	

***Detailed account of circumstances including time and date of incident leading to the request for a Child Protection medica**l:	
What would you want to achieve from this medical?	

Community Paediatric CP Admin to complete:

Written request received:	Date: Time:	
Medical records checked (Paper, ICM/IPM, ED record)? (Underline or place x as appropriate)	File exists? Yes No Notes obtainable? (if applicable) ? Yes No New file opened (if applicable)? Yes No	
Patient ID	Hosp N:	NHS No:
Name of on call Dr		
On call Dr informed	date/time	
	How? i.e. by: Face to face, Phone, Text, Email, combination of above, other :	

On call Paediatrician to complete the following:

Spoken to SW/manager? (Underline or place x as appropriate)	Yes No
Further information following discussion with Social Worker / colleague / admin / file	
Outcome? (Underline or place x as appropriate)	Medical required: Yes No Others (Explain): Reason if No: Signature: Date: Name:

	Authorised by senior doctor : (in case of trainee doctors on call)

Community Paediatric CP Admin to complete:

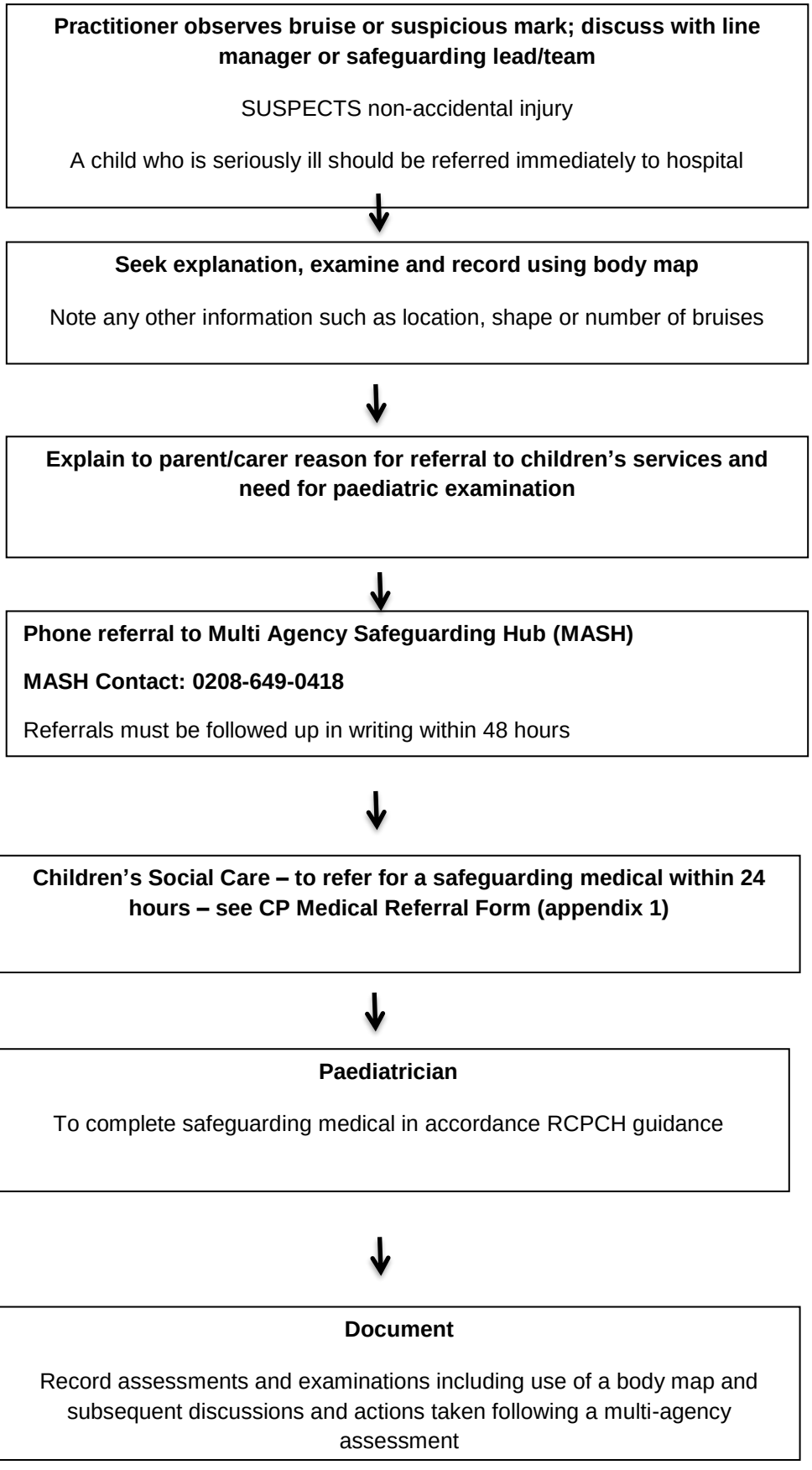
Response from on call Dr received (date / time)		
Action taken by CP admin (as per Dr instruction)	Date /time: Actions:	
Date, time and place of medical arranged:		
Name Dr on call for CP:		
Name of Dr Conducting medical:		
SS informed and agreed:	Yes No Details of any problem:	
Medical done (date and time)		
Medical dictation received (date / time)		
Med Report typed and given to Dr (date/time)		
Signed report received by CP admin (date / time)		
Med report sent out (date / time)		
Med Report Sent out by (Underline as appropriate)	Email, Fax, Post, Email/Post, Fax/Post, Other	

Notes:

- Please contact Community Paediatric CP admin on 020 8296 4854 first then forward the completed form via a secure email to est-tr.ChildSafeguardingQMHC@nhs.net or fax to Lisa Freeman on 020 8296 4864**.** *Email is preferred than fax so that we can also continue typing into the same form in the relevant sections.*
- Office hours for CP admin: **0900 -1700 hours Mon-Fri**
- CP medicals by Community Paediatrician takes place between **0900 and 1600 hours Mon-Fri**
- If 'Out of Hours', please contact the on call Paediatric Registrar via hospital switchboard on 020 8296 2000 and ask for bleep number: 197.

Appendix 2

Multi-agency flowchart for the management of actual or suspected bruising in Infants who are not independently mobile



Appendix 3 Body map template

Body Maps

Child's name:

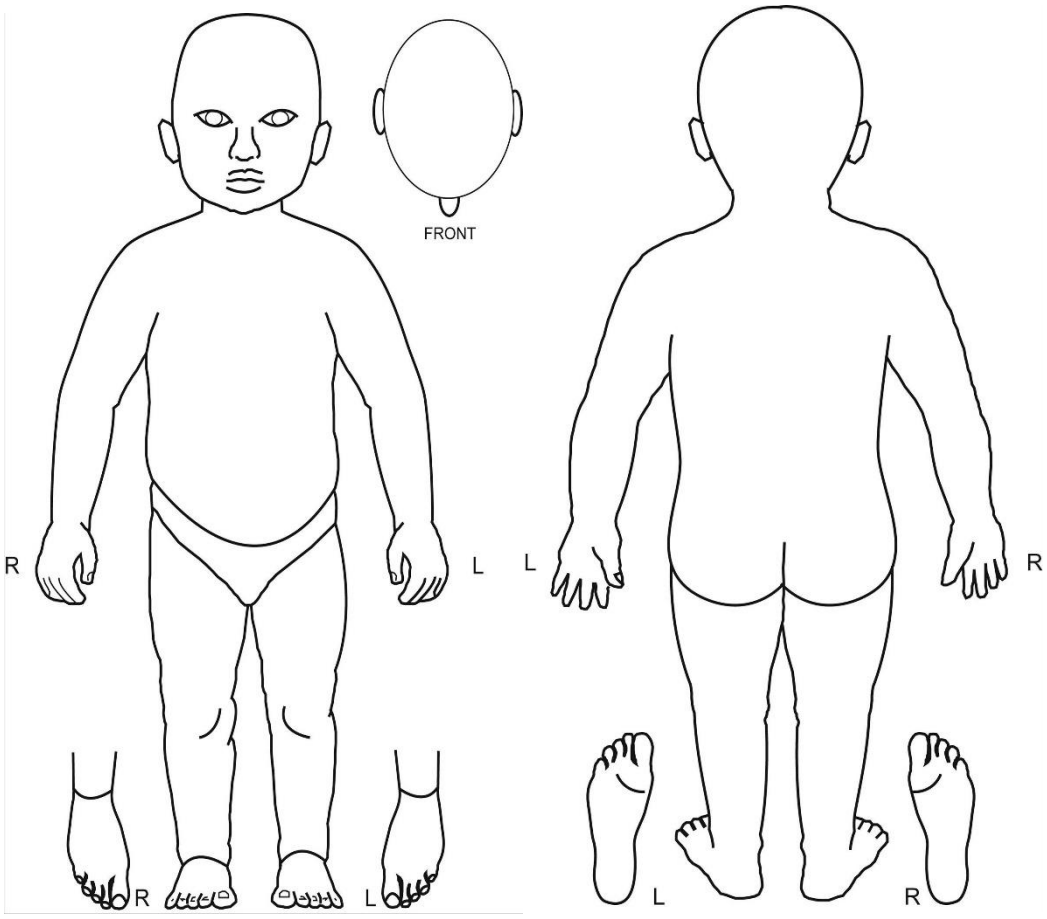
Date of birth:

Date/time of skin markings/injuries observed:

Who injuries observed by:

Information recorded: **Date:** **Time:**

Name: **Signature:**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Appendix 1 NICE Guidelines (2009), Child Maltreatment: When to Suspect Maltreatment in Under 18s (CG89)

1.1 Physical features

Bruises

1.1.1 Suspect child maltreatment if a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

1.1.2 Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable[4].

Examples include:

- bruising in a child who is not independently mobile
- multiple bruises or bruises in clusters
- bruises of a similar shape and size
- bruises on any non-bony part of the body or face including the eyes, ears and buttocks
- bruises on the neck that look like attempted strangulation
- bruises on the ankles and wrists that look like ligature marks.

Bites

1.1.3 Suspect child maltreatment if there is a report or appearance of a human bite mark that is thought unlikely to have been caused by a young child.

1.1.4 Consider neglect if there is a report or appearance of an animal bite on a child who has been inadequately supervised.

Lacerations (cuts), abrasions and scars

1.1.5 Suspect child maltreatment if a child has lacerations, abrasions or scars and the explanation is unsuitable[4]. Examples include lacerations, abrasions or scars:

- on a child who is not independently mobile
- that are multiple
- with a symmetrical distribution
- on areas usually protected by clothing (for example, back, chest, abdomen, axilla, genital area)
- on the eyes, ears and sides of face
- on the neck, ankles and wrists that look like ligature marks.

Thermal injuries

1.1.6 Suspect child maltreatment if a child has burn or scald injuries:

- if the explanation for the injury is absent or unsuitable[4] or

- if the child is not independently mobile
- or on any soft tissue area that would not be expected to come into contact with a hot object in an accident (for example, the backs of hands, soles of feet, buttocks, back) or
- in the shape of an implement (for example, cigarette, iron) or
- that indicate forced immersion, for example:
    - scalds to buttocks, perineum and lower limbs
    - scalds to limbs in a glove or stocking distribution
    - scalds to limbs with symmetrical distribution
    - scalds with sharply delineated borders.

Cold injury

1.1.7 Consider child maltreatment if a child has cold injuries (for example, swollen, red hands or feet) with no obvious medical explanation.

1.1.8 Consider child maltreatment if a child presents with hypothermia and the explanation is unsuitable[4].

Fractures

1.1.9 Suspect child maltreatment if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity) or if the explanation is absent or unsuitable. Presentations include:

- fractures of different ages
- X-ray evidence of occult fractures (fractures identified on X-rays that were not clinically evident). For example, rib fractures in infants.

Intracranial injuries

1.1.10 Suspect child maltreatment if a child has an intracranial injury in the absence of major confirmed accidental trauma or known medical cause, in one or more of the following circumstances:

- the explanation is absent or unsuitable[4]
- the child is aged under 3 years
- there are also:
- retinal haemorrhages or
- rib or long bone fractures or
- other associated inflicted injuries
- there are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage (damage due to lack of blood and oxygen supply) to the brain.

Eye trauma

1.1.11 Suspect child maltreatment if a child has retinal haemorrhages or injury to the eye in the absence of major confirmed accidental trauma or a known medical explanation, including birth-related causes.

Spinal injuries

1.1.12 Suspect physical abuse if a child presents with signs of a spinal injury (injury to vertebrae or within the spinal canal) in the absence of major confirmed accidental trauma. Spinal injury may present as:

- a finding on skeletal survey or magnetic resonance imaging
- cervical injury in association with inflicted head injury
- thoracolumbar injury in association with focal neurology or unexplained kyphosis
- (curvature or deformity of the spine).