Knowsley Safeguarding Children Board

Pan Merseyside Protocol for:

Bruising in Children who are Not Independently Mobile

A Protocol for Assessment, Management and Referral by Health Practitioners

Aim of Protocol

The aim of this protocol is to provide frontline and senior multi agency professionals with a knowledge base and action strategy for the assessment, management and referral of children who are Not Independently Mobile (NIM) who present with bruising or otherwise suspicious marks.

It does not replace the process to be followed once a referral to Children's Social Care has been made. For this, practitioners must consult the Knowsley Local Safeguarding Children Board Child Protection Procedures.

Target Audience:

All front line clinical staff: general practitioners including sessional doctors, locums and GP trainees; primary care staff including practice nurses; health visitors, district nurses, school health advisers and midwives; community staff allied to medicine; clinicians in GP out of hours services, urgent care centres, minor injury units and emergency departments; dentists and allied professionals; community and hospital paediatric clinical staff.

All front line multi agency staff: who are made aware of a bruise in a NIM child.

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Developed with assistance of KLSCB Health-Sub Group representing health agencies / services

LT May 2018 *revision date May 2021*

1. Introduction

1.1 Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews have indicated that clinical staff have sometimes underestimated or ignored the highly predictive value for child abuse, of the presence of bruising in children who are not independently mobile (those not yet crawling, cruising or walking independently).

As a result there have been a number of cases where bruised children have gone on to suffer other significant abuse that might have been prevented if action had been taken at an earlier stage.

While this protocol by necessity focuses on children who are not independently mobile due to their age, the information in this protocol is also relevant to children of all ages who are not independently mobile.

1.2 The NICE guideline "When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009, updated October 2017)" states that bruising in any child not independently mobile should prompt suspicion of maltreatment. **http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English** .

1.3 In the light of these findings a joint protocol has been developed for health and multiagency practitioners, for the assessment and management of bruising in children who are not independently mobile and the process by which such children must be referred to Children's Social Care and a Child Protection for further assessment and investigation of potential child abuse. The protocol has been approved by Knowsley Local Knowsley Children's Safeguarding Board.

1.4 In the light of the NICE guideline and the research base outlined in section 3 this protocol is necessarily directive. While it recognises that professional judgement and responsibility have to be exercised at all times, it errs on the side of safety by requiring that **the majority of children with bruising who are not independently mobile be referred to Children's Social Care for a Child Protection medical.** Professionals must always have a higher rate of suspicion when a child is not independently mobile and there is no explanation for the injury, or explanations change during interview, or delay in presentation.

2. Definitions

2.1 **Not Independently Mobile**: a child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. This includes all children under the age of six months and any older child who is not independently mobile due to a physical impairment.

2.2 **Bruising**: when blood vessels are damaged, there is extravasation (leakage) of blood into the surrounding soft tissues, producing a temporary, non- blanching discolouration of skin however faint or small. There may be no other associated signs, or other signs may be present including abrasions, lacerations, swelling or a clear pattern to the bruising. Colouring may vary from yellow through green to brown or purple. Bruising can include petechiae (pin head haemorrhages) which are seen as red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

There needs to be a mechanism of trauma to explain the damage to the blood vessels, resulting in bruising. Most bruising is due to trauma, usually blunt force trauma or occasionally suction trauma. In a few cases bruising may be the result of infection or medical disorder such as an underlying connective tissue disorder or haematological condition. The opinion and differential diagnosis is the responsibility of an appropriately experienced doctor.

For any bruise in a not independently mobile child there needs to be a credible and plausible explanation to account for the bruise.

A cautionary note: lying on a surface or object is not sufficient to cause trauma so it cannot always be accepted as a valid explanation for a bruise, even if this was for some time.

3. Research base

3.1 There is a substantial and well-founded research base on the significance of bruising in children. See Paediatric Care Online: http://www.rcpch.ac.uk/pcouk-subscribe.

3.2 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,

Moreover, the pattern, number and distribution of innocent bruising in non-abused children is different to that in those who have been abused. Innocent bruises in mobile children 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,

3.3 Patterns of bruising suggestive of physical child abuse include:

- bruising in children who are not independently mobile
- bruising in babies
- bruises that are away from bony prominences
- bruises to the face, back, abdomen, arms, buttocks, ears and hands
- multiple or clustered bruising
- imprinting and petechiae
- symmetrical bruising
- bruising in intimate areas also raises the possibility of sexual abuse

3.4 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.

3.5 The younger the child the greater the risk that bruising is non-accidental and the greater potential risk to the child.

4. Scope of Protocol

4.1 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 a health professional must be taken as a matter for inquiry and concern. This protocol relates only to bruising in children who are not independently mobile, that is to say children who are not yet crawling, shuffling, pulling to stand, cruising or walking independently.

4.2 It is not always easy to identify with certainty a skin mark as a bruise. The mark maybe innocent (see section 8 below) e.g. a “Mongolian Blue Spot”. If the practitioner is uncertain they must discuss the findings with a senior colleague

4.3 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 and there is an insufficient history of a mechanism to produce the bruising.

4.4 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 must 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.

4.5 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

5. Emergency Admission to Hospital

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

5.2 Such a referral must 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**

5.3 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.

6. Referral to Children’s Social Care

6.1 **In not independently mobile children, the presence of any bruising, of any size in any site** must **initiate a detailed examination and inquiry into its explanation, origin, characteristics and history.** Professionals must always have a higher rate of suspicion when a child is not independently mobile and there is no explanation for the injury or explanations change during interview. **In most instances it is expected that this will result in referral to Children's Social Care**.

6.2 In the case of new born infants where bruising may be the result of birth trauma or instrumental delivery, professionals must remain alert to the possibility of physical abuse even in a hospital setting. In this situation clinicians must take into account the birth history, the degree and continuity of professional supervision and the timing and characteristics of the bruising before coming to any conclusion. It is particularly important that accurate details of any such bruising must be communicated to the infant's general practitioner, health visitor and community midwife. **Where practitioners are uncertain whether bruising is the result of birth injury they must refer immediately to the duty consultant paediatrician.**

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.

6.3 Wherever possible, the decision to refer must be undertaken jointly with another professional or senior colleague. However this requirement should not prevent an individual professional of any status referring to Children's Social Care any child with bruising who in their judgement may be at risk of child abuse.

6.4 If a referral is not made, the reason must be documented in detail with the names of the professionals taking this decision. The referrer will receive an update of the outcome of the referral, if not the referrer should request an update. If there are any issues regarding the feedback that cannot be resolved with the MASH CSC Team Manager or MASH Coordinator then referrers should follow the KSCB escalation policy located on the KSCB website.

6.5 Children's Social Care should take any referral made under this protocol as requiring further multi-agency investigation and must contact the consultant paediatrician, to arrange a Child Protection medical before reaching any conclusions on the case.

6.6 Referral must, in the first instance, be made by phone: **During office hours and OOH to Knowsley Access Team (MASH): 0151 443 2600**

6.7 All telephone referrals must be followed up within 48 hours with a written referral, using the appropriate Multi-Agency Referral Form and must be fully documented in the patient records.

6.8 The referrer must record the joint action plan agreed with Children's Social Care including any health follow-up.

7. Involving Parents or Carers

7.1 As far as possible, parents or carers must be included in the decision-making process unless to do so would jeopardise information gathering or pose a further risk to the child.

7.2 In particular professionals must explain at an early stage why, in cases of bruising in not independently mobile children, additional concern, questioning and examination are required. The decision to Children's Social Care should be explained to the parents or carers frankly and honestly.

7.3 Consent must be sought for referral, however in case the carers/parent do not consent, this must be overridden in the best interest of the child as the 'welfare of the child is paramount'. Consent need not be sought if the practitioner feels this would place the child at risk of further harm

7.4; If a parent or carer is uncooperative or refuses to take the child for further assessment, this must be reported immediately to Children's Services. If possible the child should be kept under supervision until steps can be taken to secure his or her safety.

8. Innocent Bruising

8.1 It is recognised that a small percentage of bruising in not independently mobile children will have an innocent explanation (including medical causes). Nevertheless because of the difficulty in excluding non-accidental injury, practitioners must seek advice from a consultant paediatrician and from Children's Social Care in all cases. It would be dangerous in non-mobile children for professionals to diagnose innocent bruising, including general practice, without significant expertise and other investigations.

8.2 It is the responsibility of Children's Social Care in conjunction with the local acute or community paediatric department to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not.

8.3 In general practice any history of bruising must be flagged as a significant problem/risk factor in the notes.

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

8.5 Practitioners must take into consideration cultural practices and racial characteristics when assessing bruising, including communication difficulties. However no cultural practice should harm a child.

8.6 A Mongolian Blue Spot is a form of birth mark. They are rare in white European children but very common in children of African, Middle Eastern, Asian or Mediterranean ethnicity including those of descent. Although the birthmark is congenital it may not be visible at birth but become apparent some weeks later; parents may not have noticed the mark before the professional.

A Mongolian Blue Spot can be single or multiple marks, vary in size from few centimetres to extensive. They can be present anywhere on the body and are common on buttocks, lower back, occasionally on limbs but rarely on head or face. They are flat and predominantly a uniform colour ranging from light grey to very dark blue. Unlike a bruise there is no variation of colour over days as in a resolving bruise and are not associated with other signs sometimes found with bruising such as tenderness and swelling.

Mongolian Blue Spots do not need treatment. They fade with time and are usually not visible

after a number of years. It is important that should a health professional identify birth marks that they are recorded in the “red book” ideally with a body map.

9. Sharing Information and Consulting Colleagues

9.1 The case and findings must be shared and discussed with another professional or senior colleague. For non-health practitioners advice must be sought from a health practitioner with sufficient experience and expertise to assist in the further management of the child. Child protection issues are necessarily complex and seeking advice from a colleague protects against professional optimism and promotes safe practice.

9.2 In primary care a general practitioner may discuss concerns with safeguarding lead or Named GP for advice, provided this is timely and causes no undue delay in referral. Concerns must also be notified to the child’s health visitor and vice versa.

9.3 In the general practice out of hours service such a discussion must take place either with the clinical director of the service, or with a senior colleague.

9.4 In the hospital emergency department, the discussion must be with the most senior clinical colleague available.

9.5 Health staff must seek advice or discuss the case with their Safeguarding Children Team but if unavailable, should not delay referral. In these circumstances the Safeguarding Children Team must be notified as soon as possible following referral.

9.6 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.

9.7 Whenever possible, the child's parent or carer must 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 belief that a child may be suffering, or be at risk of suffering, significant harm. (*Working Together to Safeguard Children, HM Government 2015*)

10. History Taking and Examination

10.1 A cogent and credible explanation for the bruising must be sought at an early stage from parents or carers and recorded. It is important to undertake this with open questioning and to avoid leading questions.

10.2 The lack of a satisfactory, or a consistent explanation or an explanation incompatible with the appearance or circumstances of the injury, or with the child’s age or stage of development or a delay in seeking medical advice must raise suspicions of abuse.

10.3 If possible history should be sought from more than one carer separately or more than once from the same carer. Inconsistencies or variations between carers or between interviews should raise suspicions of abuse.

10.4 A health practitioner should undertake a full physical examination of the completely undressed child. This should include weighing, observation of general demeanour, cleanliness, infestations, nourishment and body proportion, as well as looking for other bruising or evidence of injury. If available, the child's growth chart should be examined.

10.5 All information known at presentation must be included in the referral to Children's Social Care and the paediatrician. To assist in the final interpretation of a finding and a diagnosis of non-accidental or innocent injury, a review of the child's medical history, including any previous occurrence of bruising or injury, must be undertaken. Other health records may need to be reviewed. Consideration must be given to identify vulnerabilities within the family such as domestic abuse, substance misuse, and mental health issues and deliberate self-harm. It is unlikely that all information will be available to the referrer when initial concerns arise.

10.6 Where a history of previous child protection concerns is given by Children's Social Care this information must be recorded in the health record.

10.7 In all cases careful mapping, description and recording of the size, colour characteristics, site, pattern and number of the bruises must be made preferably on a body diagram (Appendix A), and a careful record of the carers/parents description of events and explanation for the bruising made in the clinical notes. GP records must be flagged as "at risk" if concerns remain.

If a child safeguarding medical examination takes place under child protection procedures the relevant hospital documentation must be completed.

10.8 The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be overemphasised.

11. Assessing the Significance of Bruising

11.1 Bruising is the commonest presenting feature of physical abuse in children.

11.2 Colour of the bruise cannot be used to accurately time the bruising.

The younger the child the greater the risk that bruising is non-accidental.

The following features indicate an increased risk that bruising is due to abuse rather than to accidental or medical reasons. Consideration should be given to the degree, if any, to which these features are present taking into account the age and ability of the child:

- 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
- In some areas of the body, such as the cleft of the buttocks and the ears, bruising caused

by an object or implement may not always show a typical imprint of the injuring object.

- 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 disabled children

11.3 Features of innocent bruising:

- In mobile children, the commonest sites of bruising are the shins and the knees
- Bruising as a result of trips and falls is commonest on the back of the head, the front of the face, including the forehead, the nose, upper lip and chin
- Children who are pulling to stand may bump their head sustaining bruising to the forehead

However, these features may also occur in abused children and it is important to re-emphasise that any bruising in a not independently mobile child is unusual.

12. Other Sources of Guidance and Information

Working Together to Safeguard Children, HM Government, 2015

http://www.workingtogetheronline.co.uk/resources.html

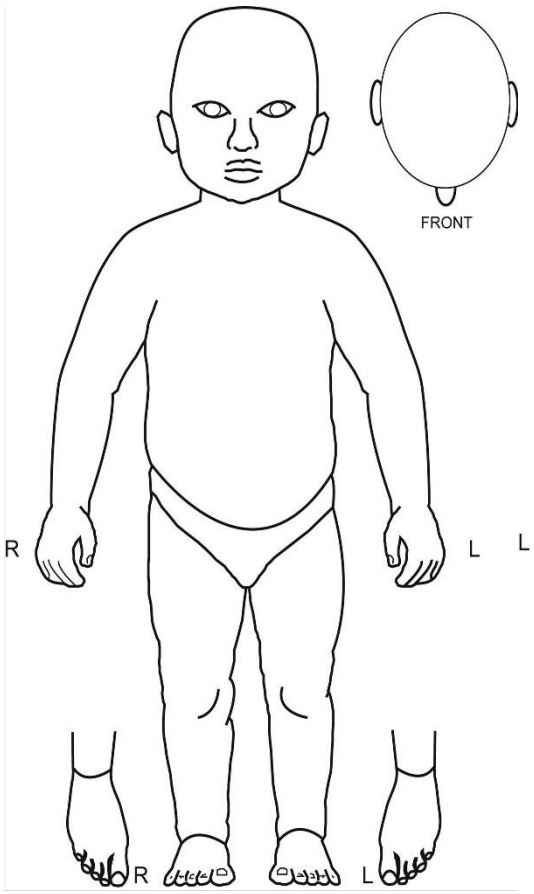
What to Do If You Are Worried a Child Is Being Abused, HM Government, 2006
http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182/
Child Protection Companion, Royal College of Paediatrics & Child Health, April 2013

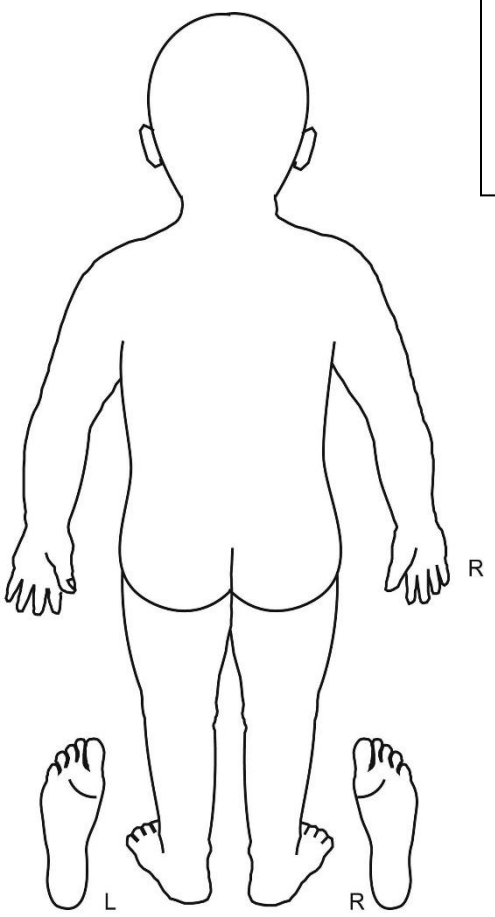
http://www.rcpch.ac.uk/doc.aspx?id_Resource=1521

When to Suspect Child Maltreatment (NICE Clinical Guideline 89, July 2013)
http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English .

This protocol has been adapted from that which was initially developed for use by the Hampshire, Southampton, Portsmouth and Isle of Wight Local Safeguarding Children Boards.

Appendix A
Skin Map





Key

Child's name:

Date of birth:

Date/time of skin markings/injuries observed:

Who injuries observed by:

PROTOCOL FOR INJURIES IN NON-MOBILE CHILDREN[1]

Professional observes an
INJURY, BRUISE OR SUSPICIOUS MARK

You Must Suspect Child Maltreatment

1. **Seek an explanation, examine and record accurately.**
2. **This must include details of social history including other children and carers**
3. **Refer to Children's Social Care**
4. **A Child who is seriously ill must be referred to the hospital immediately**

Follow the Knowsley Safeguarding Children's Board Child Protection Procedures
http://knowsleyscb.proceduresonline.com/index.htm

Refer Child immediately to Children's Social Care for a Child Protection Medical

T: 0151 443 2600

Inform GP & Health Visitor

If a medical cause is suspected advice should be sought from the Consultant Paediatrician on

call Tel. 0151 252 5609

[1] Definition of Non-Mobile: Babies who are not yet crawling, shuffling, pulling to stand, cruising or walking independently. The guidance also applies to older immobile children, for example immobility due to disability/illness.

INJURIES IN NON-MOBILE CHILDREN

Protocol Summary

The protocol provides all agency professionals with a knowledge base and action strategy for the assessment, manag
are non- mobile who present with injuries (including bruising or suspicious marks).

Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, *must be referred immediately to hospital before referral to Children's Social Care.*

Bruising is the commonest presenting feature of physical abuse in children. The younger the child the greater the risk that bruising is non-accidental. There is a substantial and well-founded research base on the significance of bruising in children. RCPCH systemic reviews.

Any injury, bruising, or mark that might be bruising, in a child of any age that is brought to the attention of a Professional should be taken as a matter of concern. Injuries in a non-mobile child must raise suspicion of maltreatment and must result in an immediate referral to Children's Social Care and an urgent paediatric opinion. NICE Clinical Guideline 89: http://guidance.nice.org.uk/CG89/Guidance/pd f/English

An injury 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 by a paediatrician.
An injury 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 by a paediatrician.

Innocent bruising is rare. It is the responsibility of Children's Social Care and the local acute hospital to decide whether bruising is consistent with an innocent cause or not

Parents or carers must be included as far as possible in the decision-making process providing this does not pose a further risk to the child. If a parent or carer is uncooperative or refuses to take the child for further assessment, this must be reported immediately to Children's Social Care: https://marf.knowsley.gov.uk/Home

Information must be shared between the child's GP and Health Visitor and the case should be discussed with a professional or senior colleague such as the Area Safeguarding Children Team or the Trust Safeguarding Children Team.

The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be over- emphasized - body maps can be used. Once a referral to Children's Social Care Definition of Non-Mobile: Babies who are not yet crawling, shuffling, pulling to stand, cruising or walking independently. The guidance also applies to older immobile children, for example immobility due to disability/illness,

has been made, practitioners must follow the KSCB Safeguarding Children Procedures:

http://knowsleyscb.proceduresonline.com/index.htm

Where a decision to refer is made, it is the responsibility of the first professional to learn of or observe the injury to make the referral. All telephone referrals should be followed up within 48 hours with a written referral using the appropriate interagency referral form.