Bruising and Injuries to Non-Mobile Children

This chapter was added to the manual in June 2016.

Contents

1. Introduction

The safety of children and their protection is everybody's business. Although bruising is the commonest presenting feature of physical abuse in children this procedure covers all actual or suspected injuries to non-mobile children.

Any bruising, fractures, bleeding and other injuries such as burns should be taken as a matter of enquiry and concern.

It has been developed for frontline workers and managers, for the management and investigation of bruising or injuries in children who are not independently mobile and to clarify process by which such children will be managed within existing multi-agency child protection procedures.

National serious case reviews and local individual child protection cases have indicated that staff have sometimes underestimated the significance of the presence of bruising or minor injuries in children who are not independently mobile. They have therefore not considered what appears to be a rather minor injury as an

indicator or precursor to significant injuries or death of a child. **Early recognition and action in such cases is key to preventing further injuries.**

2. Terminology

- **Not Independently Mobile**: a baby who is not crawling, bottom shuffling, pulling to stand, cruising or walking independently. Includes all children under the age of six months and **any** children with a disability who are not able to move independently. Babies who can roll or sit independently are classed as **non-mobile** for the purposes of this document;
- **Bruising**: blood coming out of the blood vessels into 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 tiny red or purple non-blanching spots, less than two millimetres in diameter and often in clusters;
- **Minor injuries** may include (but are not confined to) torn frenulum; grazing; abrasions; minor cuts; blisters; injuries such as bruises, scratches, burns/scalds, eye injuries e.g. sub-conjunctival haemorrhages/corneal abrasions, bleeding from the nose or mouth, bumps to the head.

Any bruising, fractures, bleeding and other injuries such as burns should be taken as a matter of enquiry and potential abuse unless otherwise evidenced.

3. What Research Tells Us

- Bruising in a baby who has no independent mobility is very uncommon - Kemp (2015) has found that 2.2% of non-mobile babies will have bruises. It may be an indicator of a serious medical condition or physical abuse;
- Severe child abuse is 6 times more common in babies aged under 1 year than in older children. Infants under the age of one are more at risk of being killed at the hands of another person (usually a carer) than any other age group of child in England and Wales;
- Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission;
- Multi-agency information sharing allows for sensible, informed judgements regarding the child's safety to be made;

- Moreover, the pattern, number and distribution of accidental bruising in non-abused children is different to that in those who have been abused. Accidental 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 of the feet;
- Patterns of bruising suggestive of physical child abuse include:
    - Bruising or injuries in children who are not independently mobile;
    - Bruising or injuries in babies;
    - Bruises that are away from bony prominences;
    - Bruises to the face, back, abdomen, arms, buttocks, ears or hands;
    - Multiple or clustered bruising;
    - Imprinting and petechiae;
    - Symmetrical bruising.
- 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 by a suitably qualified paediatrician.

While professional judgement and responsibility have to be exercised at all times, it errs on the side of safety to require that professionals refer to **Children's Social Care all children with bruising or injuries who are not independently mobile**.

4. Presentation at Clinic / GP Practice / Walk in Centre or Minor Injuries Unit

Due to the significant risk of abusive injury **ALL** non-mobile babies with an injury or bruising should be considered as a potential indicator of abuse unless evidenced otherwise by the health professional e.g. marks/bruising such as those caused by immunisations; medical interventions; traumatic delivery; Mongolian blue spot. Where a child presents at a health clinic; GP practice, walk in centre or minor injuries unit with bruising or minor injuries they must be referred to Children's Social Care without delay or EDS out of hours.

Where a child is presented at the Emergency Department Children's Social Care/EDS should be notified and the child protection process followed.

Any injuries in non-mobile babies, however minor are cause for concern.

5. Emergency Assessment and Treatment Requiring Hospital Admission

Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be transported immediately to hospital for assessment and treatment. **It is important to ensure that the child's medical needs are treated first.** A referral should then be made to Children's Social Care and the child protection procedures followed.

6. Referral to Children's Social Care

In non-mobile children, the presence of any injury including bruising, of any size, in any site should initiate an inquiry into its explanation, origin, characteristics and history. It is recognised that a small percentage of bruising in not independently mobile children will have an innocent explanation (including medical causes). This will include where it is believed that the mark is a benign skin mark (birth mark or Mongolian blue spot).

The professional who has learnt of or observed the injury should consult with their agency Safeguarding Lead/Advisor without delay. Any non-abusive explanations for the bruising or injury provided by the parents/carers should be discussed with the Safeguarding Lead/Advisor where in place within the organisation or Children's Social Care consulted to inform next steps.

Any other obvious explanations for the injury or bruising should not automatically be referred but a consultation with the safeguarding advisor should take place and the detail of what has been observed and discussed should be recorded, dated, timed and signed in the child's individual record held by the agency.

Where there are concerns as to the cause or origin of the bruising/injury the Safeguarding Lead/Advisor will refer the matter to Children's Social Care or Emergency Duty Service out of hours. In the absence of the Safeguarding Lead/Advisor the professional must refer directly to Children's Social Care or the Emergency Duty Service out of hours.

The detail of what has been observed and discussed should be recorded, dated, timed and signed in the child's individual record held by the agency and followed up in writing as part of the referral to Children's Social Care.

In all instances the agency professional should follow the agreed procedures for consulting on, referring and recording child protection concerns. Please refer '**What to do if you are worried a child is being abused**'.

If a decision is made not to make a referral the reason must be documented in detail with the names of the professionals making this decision. Where there is not an agency Safeguarding Lead in place or available, the professional must refer Children's Social Care/EDS unless absolutely confident that the bruising/injury is not indicative of abuse.

7. Children Subject to a Child Protection Plan or Known to Children's Social Care

Where the child or siblings are subject of a child protection plan the matter must be referred immediately to the child's/siblings social worker or manager in their absence.

Where children's social care staff are made aware of or observe the injury/bruise (whether Child Protection, Child in Need, Looked After or Special Educational Needs or Disability) the child protection process will be followed. (See below)

8. Action Following Referral

Where a child is referred to Children's Social Care or where the child is already known to Children's Social Care in any capacity, the child protection procedures should be followed. This will include gathering information from relevant agencies and speaking to the parents/carers.

Strategy Discussion

In **all** cases where there is any doubt about the cause of bruising or injuries and concerns that the child may be at risk of suffering significant harm, Children's Social Care will convene a strategy discussion within 24 hours.

A medical assessment should always be arranged and undertaken within 24 hours.

The medical assessment will be completed by a suitably trained and experienced paediatrician who will be able to give a view regarding the nature and cause about the injury.

A Local Authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion. Other relevant professionals will depend on the nature of the individual case and time available.

A Strategy Discussion may be in the form of a telephone discussion or a meeting. If on the same day as the concerns are raised, then it is likely that this will be in the form of a telephone discussion. Urgent action to safeguard the child may be required.

Purpose of a Strategy Discussion

The purpose of a strategy discussion is to:

- Share available information;
- Agree the conduct and timing of any criminal investigation;
- Decide whether enquiries under Section 47 of the Children Act 1989 should be undertaken (S47 Enquiry).

Section 47 Enquiries (S47) will be undertaken where there are concerns that a child may be at risk of suffering significant harm.

Where there are grounds to initiate a S47 enquiry, decisions should be made as to:

- What further information is needed and how it will be obtained and recorded;
- Determine the timing of the child protection medical examination;
- What immediate and short term action is required to support the child, and who will do what by when;
- Whether legal action is required;
- Consider the needs of any other children who may be affected;
- What further information is needed if an assessment is already underway and how it will be obtained and recorded;
- Where a child is in hospital how to manage contact and how to secure the safe discharge of the child.

9. Outcome of Child Protection Medical Examination

Where the medical examination concludes the cause of the injury is accidental or consistent with the explanation given or has a clear medical explanation, the paediatrician will discuss their findings with Children's Social Care. Any further interventions/support required will be considered by Children's Social Care in consultation with partner agencies.

Where medical examination is inconclusive or there are concerns as to how the bruise/injury has been caused Children's Social Care in consultation with police and medical staff will consider any further investigations/support required including any emergency action required to safeguard the child or any other children as part of S47 enquiries.

Following the conclusion of S47 enquiries Children's Social Care will determine any further interventions or support for the child and family including whether the child is in need or in need of protection.

10. Involving Parents/Carers

Children's Social Care have the prime responsibility to engage with parents and other family members to ascertain the facts of the situation causing concern and to assess the capacity of the family to safeguard the child.

In most cases, parents should be enabled to participate fully in the enquiry and assessment process. Social workers should interview the parents/carers and determine the wider social and environmental factors that might impact on them and their child. The needs and safety of the child will be paramount when determining at what point parents or carers are given information.

Particular attention should be paid to communication with parents who may have difficulty understanding the explanation, for example parents whose first language is not English or parents with learning difficulties.

Where a professional has concerns about the nature and cause of an injury or bruise they should explain at an early stage why, in cases of bruising or minor injuries in not independently mobile children, additional concern, questioning and examination are required. The decision to refer to Children's Social Care should be explained to the parents or carers frankly and honestly.