

Hampshire, Isle of Wight, Portsmouth & Southampton LSCPs

Protocol for the management of actual or suspected bruising in infants who are not independently mobile

Version 1	Ratified	2010
Version 2	Reviewed	December 2013
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Version 7	To be reviewed	Sept 2020



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1 Introduction

- 1.1 Bruising in babies who are not rolling or crawling is unusual. National and local serious case reviews have identified the need for heightened concern about any bruising in a baby who is not independently mobile. It is important that any suspected bruising is fully assessed even if the parents feel they are able to give a reason for it.

2 Aim of protocol

- 2.1 This protocol must be followed in all situations where an actual or suspected bruise is noted in an infant who is not independently mobile.
- 2.2 The term not independently mobile applies to those infants who are not yet rolling or crawling.

3 Target audience

- 3.1 All staff in the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Local Safeguarding Children Partnerships (LSCPs) areas whose work brings them into contact with children.

4 Action to be taken on identifying actual or suspected bruising

- 4.1 If the infant appears seriously ill or injured:
- Seek emergency treatment at an emergency department (ED).
 - Notify Children's Services of your concerns and the child's location.
- 4.2 In all other cases (except as stated in 4.3):
- Record what is seen, using a body map or line drawing (Appendix A).
 - Record any explanation or comments by the parent/carer word for word.
 - Refer to Children's Services who will take responsibility for arranging further multi-agency assessment. The first part of this will be a paediatric assessment, arranged by Children's Services, which the child should attend within 4 hours of receipt of the referral by Children's Services (Appendix B).
- 4.3 In the specific situation where the child has been presented to an emergency department (ED) by parents/carers and the presenting complaint is the bruise or the trauma that is reported to have led to the bruise:
- A full history must be taken, recording any explanation or comments by the parents/carers word for word.
 - The infant must be fully undressed and examined for evidence of current or past trauma and any other medical conditions.
 - Investigations or treatment necessary should be arranged promptly.
 - The child must be examined by a senior ED doctor. If there is uncertainty about the cause of the bruise a senior paediatrician should also examine the child.
 - If after review and discussion between senior colleagues child maltreatment is now suspected a referral should be made to Children's Services for a multi-agency assessment (Appendix B).
 - In all situations risk factors for abuse in the family must be considered and

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Children's Services must always be contacted by the assessing clinician to find out if any risks for abuse are known.

g) Information should also be shared routinely with health visiting and primary care.

- 4.4 Inform parents of your professional responsibility to follow HIPS LSCPs procedures and that any action by Children's Services will be informed by a paediatrician's opinion. Give parents a copy of the 'Bruising in young babies – Information for parents and carers' leaflet and answer any questions they may have.

5 Action following referral to Children's Services

- 5.1 Children's Services will arrange an urgent paediatric assessment (unless already done, as in 4.3) and gather background information about the family.
- 5.2 The child must attend for a paediatric assessment **within 4 hours** of Children's Services receiving the referral. This should 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. The paediatrician should explain the findings of the assessment to the parents.
- 5.3 A strategy discussion must take place **between the social worker, police and paediatrician** and the outcome explained to the parents. The paediatric opinion should be given about the possibility of child maltreatment on the balance of probabilities and this must be considered in the light of other information available from health (including the GP), social care and police records including the Police National Computer. The opinion should be given verbally **and in writing immediately following the paediatric assessment** (preferably using the 'PPOF – Preliminary Paediatric Opinion Form').

6 Specific considerations

- 6.1 Birth injury: Both normal birth and instrumental delivery may lead to bruising and to bleeding into the white of the eye. However, staff should be alert to the possibility of physical abuse even within a hospital setting and follow this protocol if they believe the injury was not due to the delivery.
- 6.2 Birthmarks: These may not be present at birth, and appear during the early weeks or months of life. Mongolian blue spots can look like bruising. These are rare in children of white European background, but very common in children of African, Middle Eastern, Mediterranean or Asian background. These do NOT need to be referred under this protocol. Where a practitioner believes a mark is likely to be a birthmark but requires further advice to be certain, the practitioner should seek advice from a senior colleague or the GP who should see the child the same day. If there is still uncertainty a referral should be made to Children's Services.
- 6.3 Self inflicted injury: It is very rare for non-mobile infants to injure themselves. Suggestions that a bruise has been caused by the infant hitting themselves with a toy, or hitting the bars of a cot, should not be accepted without detailed assessment by a

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paediatrician and social worker. Sometimes, even when children are moving around by themselves, there can be concern about how a mark or bruise occurred and in these situations a referral should always be made to Children's Services.

- 6.4 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 Rationale and evidence base

- 7.1 Bruising is the commonest presenting feature of physical abuse in children. Systematic review¹ of the literature relating to bruises in children shows that:

- a) Bruising is strongly related to mobility (about one in five children who are starting to walk by holding on to the furniture have bruises)
- b) Bruising in infants who are not independently mobile is unusual (2.2% of babies who are not yet rolling)²

The message from this research is that infants who have yet to acquire independent mobility (rolling or crawling) should not have bruises without a clear explanation.

- 7.2 The National Institute for Clinical Excellence (NICE) guideline 'When to suspect child maltreatment',³ aimed at health professionals, categorises features that should lead staff to 'consider abuse' as part of a differential diagnosis, or 'suspect abuse' such that there is a serious level of concern. 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 bleeding 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

- 7.3 The NICE guideline³ 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 is not independently mobile and there is an unsuitable explanation.

- 7.4 Numerous serious case reviews have identified situations where children have died because practitioners did not appreciate the significance of what appeared to be minor bruising in a non-mobile infant.

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- 7.5 National analysis of reports published as 'New learning from serious case reviews' (Department for Education 2012)⁴ reiterates the need for 'heightened concern about any bruising in any pre mobile baby....any bruising is likely to come from external sources. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the child are caused'.

8 References

- 1) Core Info Cardiff Child Protection Systematic Reviews
- 2) Kemp AM, Dunstan F, Nuttall D et al. Patterns of bruising in preschool children – a longitudinal study. *Arch Dis Child* 2015; 100: 426-431
- 3) When to Suspect Child Maltreatment, NICE Clinical Guideline 89, July 2009
- 4) New learning from serious case reviews, July 2012

9 Additional Reading

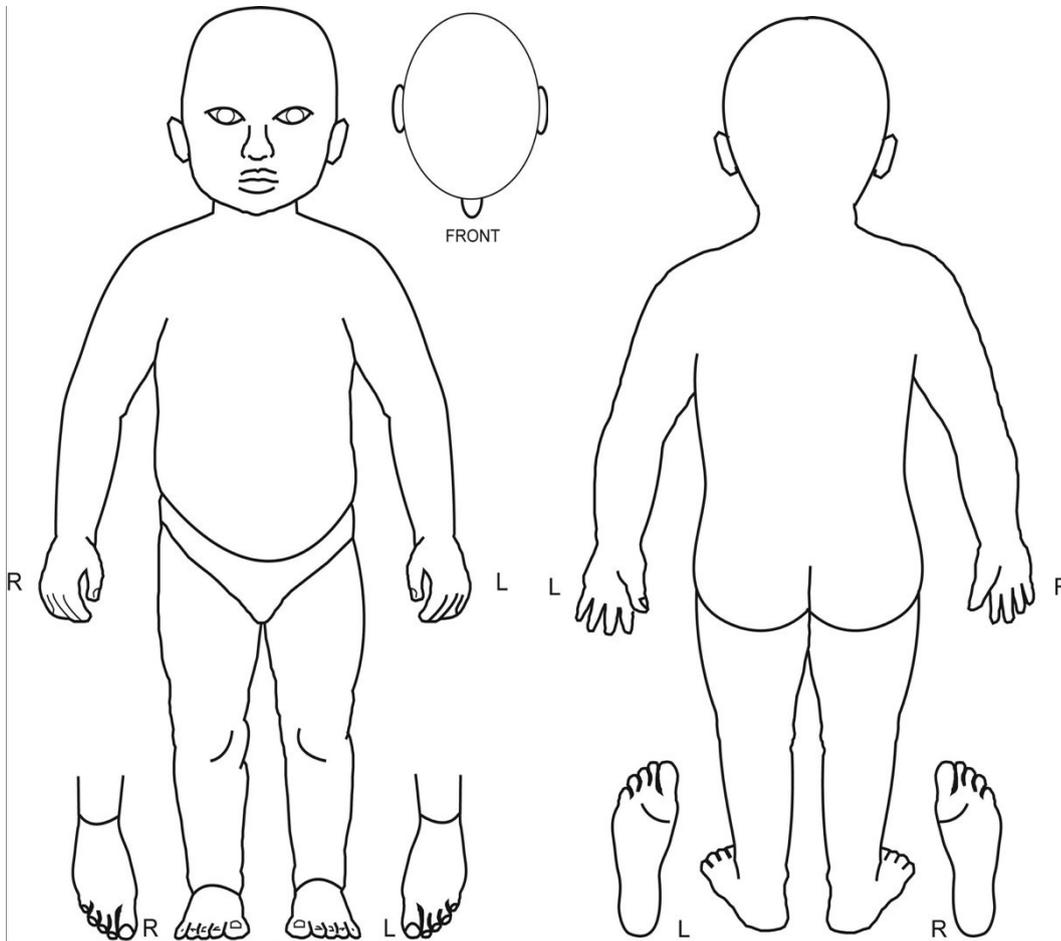
- Working Together to Safeguard Children, HM Government, March 2015
- HIPS LSCPs Procedures
- Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, DfE May 2016
- Bruising in young babies – Information for parents and carers, NHS WHCCG Sept 2016

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Appendix A Skin Map

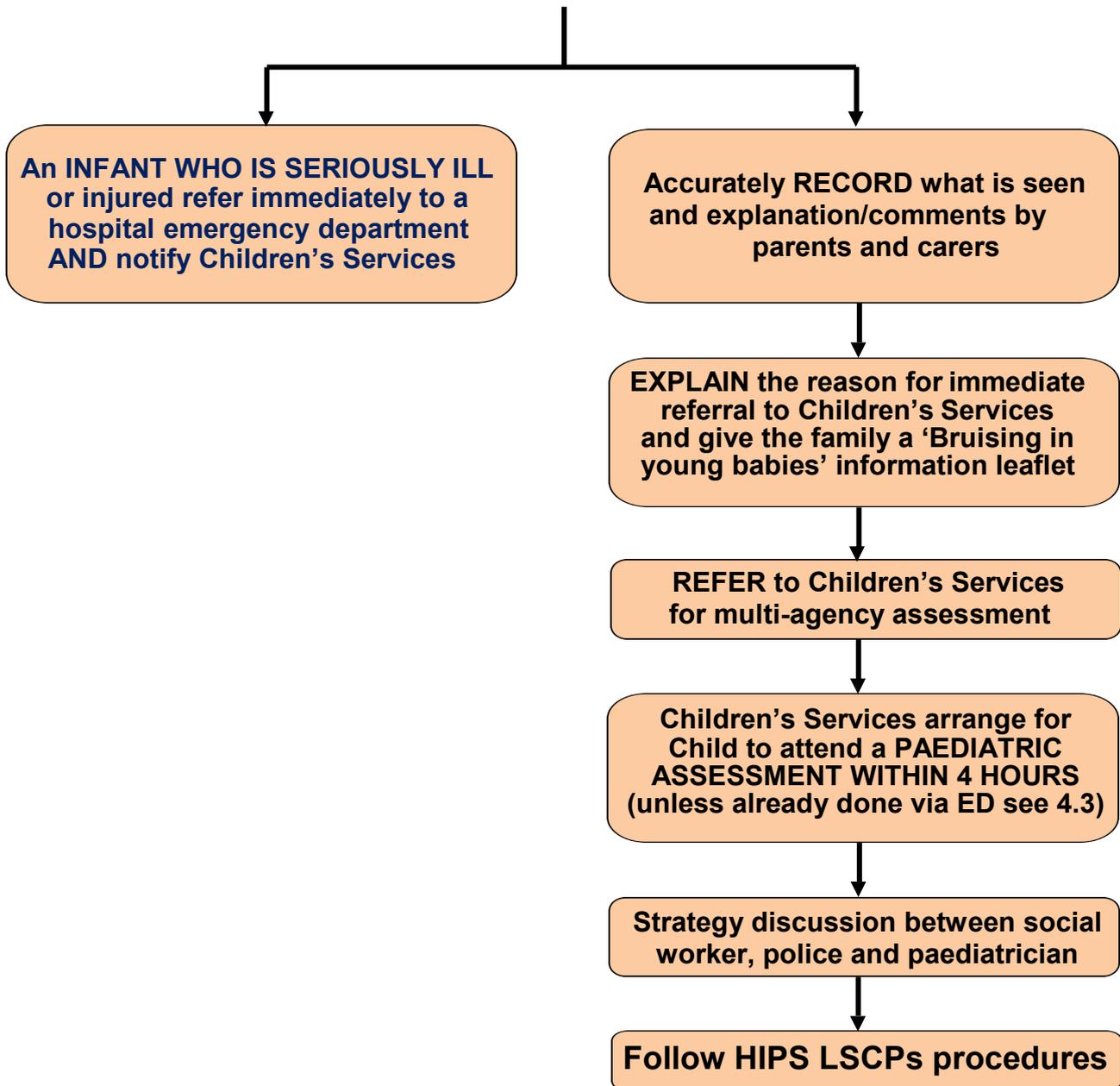
Skin map and box to record name and signature



Child's name:		
Date of birth:		
Date/time of skin markings/injuries observed:		
Who injuries observed by:		
Information recorded:	Date:	Time:
Name:	Signature:	

Appendix B
Flow Chart for the Management of actual or suspected bruising in infants who are not independently mobile

PRACTITIONER OBSERVES BRUISE
Suspect child maltreatment



CONTACT NUMBERS FOR LOCAL AUTHORITY CHILDREN'S SERVICES:

	Hampshire	Southampton	Portsmouth	Isle of Wight
Office Hours	01329 225379	023 8083 2300	023 9283 9111	0300 300 0901
Other times	0300 555 1373	023 8023 3344	0300 555 1373	0300 300 0117