Bruising & Injuries in Non-Mobile Babies & Children

Fostering

Adoption

Children & Family

Supported Accommodation

Bruising in non-mobile children is rare and there is therefore a significant risk that bruising may indicate abuse or neglectful care. Bruising is the most common presenting feature of physical abuse in children. It is recognised that the likelihood of a child sustaining accidental injuries increases with increased mobility, however Serious Case Reviews and Safeguarding Practice Reviews have identified that professionals sometimes fail to recognise the highly predictive value, for child abuse, of the presence of injuries to non-independently mobile children. Babies and children who are not yet mobile, but are observed to have bruising or an injury, should be of particular concern in terms of child protection.

This procedure sets out the required actions to take when a practitioner observes a bruise or injury or suspected bruise or injury in a non-mobile baby or child.

This procedure forms part of the Group Quality Management system ISO 9001.

Procedure Owner:	Quality Assurance & Safeguarding
Approved by:	Operations Board
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Associated Policy and supporting documents:	Safeguarding Policy
	Safeguarding Children Procedure
	NE/ME Procedure

	Response to a Serious Significant Event Case Review Procedure

All group companies are detailed in the current legal structure

Contents

Scope: All those whose work brings them into contact with children.

Definitions:

Non-independently mobile: A child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Includes all children under the age of 6 months as although some children can 'roll over' from a very early age this does not constitute self-mobility. Over 6 months, consideration must be given to the child's level of development.

This guidance also applies to children with physical disabilities who are not independently mobile. It is recognised that all children with disabilities are at increased risk of harm and abuse.

Injuries: It is recognised that bruising is the most common presentation in children who have been physically abused (Maguire, 2010). However, for the purpose of this procedure, 'injury' will be taken to mean any bruising, mark on the skin that looks like bruising or a mark that looks like an injury, burn, scald, bleeding, fracture or any other apparent injury to a child.

Bruising: Leakage of blood into the soft tissues, producing a temporary, non-blanching discolouration of skin, however faint or small, with or without other skin abrasions or marks. This includes petechiae, which are red or purple, non-blanching spots, less than two millimetres in diameter and often in clusters.

Physical Injuries: Any injury in a non-mobile infant or child causes concern. Of particular concern are injuries to infants six months and under. Any injuries are unusual in this age group. Even small injuries may be significant, and they may be a sign that another hidden injury is already present.

Such injuries include:

- Bruising in babies

- Bruising in children who are not independently mobile
- Bruises that are seen away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry an imprint, e.g. of an implement or cord
- Bruises with petechiae (dots of blood under the skin) around them.
- Small single bruises e.g. on face, cheeks, ears, chest, arms or legs, hands or feet or trunk;
- Bruised lip or torn frenulum (small area of skin between the inside of the upper and lower lip and gum);
- Lacerations, abrasions or scars;
- Bite marks;
- Burns and scalds;
- Pain, tenderness or failing to use an arm or leg which may indicate pain or discomfort and an underlying fracture;
- Small bleeds into the whites of the eyes or other eye injuries.
- Genital bruising.

The above list is not Exhaustive.

Occasionally an infant can be harmed in other ways, for example:

- Deliberate poisoning which can present as sudden collapse, coma;
- Suffocation which can present as collapse, cessation of breathing (apnoeic attack), bleeding from the mouth and nose.

Specific considerations

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 or the bars of a cot, should not be accepted without detailed assessment by a 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 Social Care.

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 care givers ability to supervise the children.

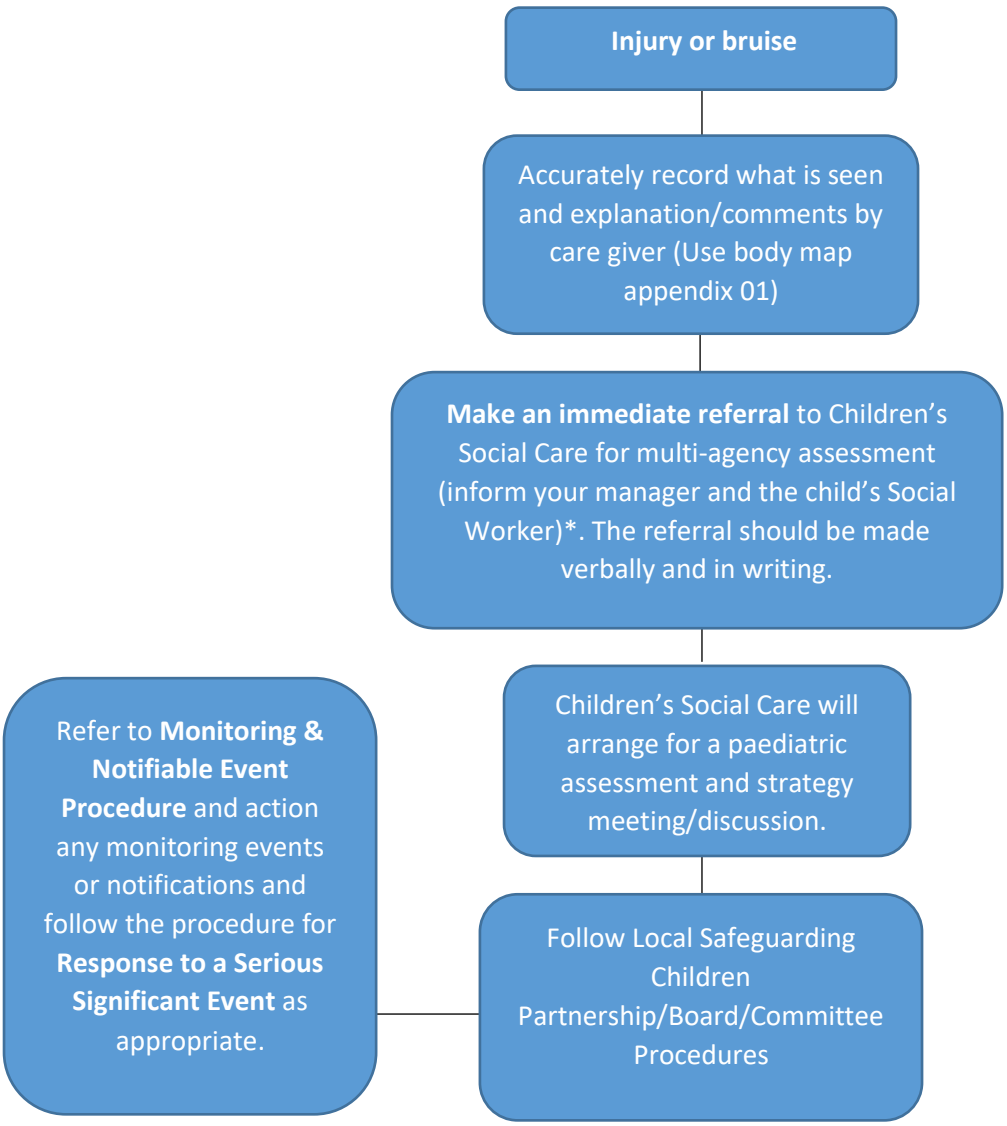
Flowchart

PRACTITIONER OBSERVES A BRUISE/INJURY or A BRUISE/INJURY/ IS REPORTED

Professional Curiosity

AN INFANT WHO IS SERIOUSLY ILL OR INJURED must be referred immediately to a hospital Emergency Department AND notify Children's Social Care immediately

Inform the child's Social Worker and your manager



***Practitioners should use their own professional judgement to determine if they need to stay with the child in order to maintain the child's safety**.

Procedure

Any bruising, injury or what is believed to be bruising or injury in a child of any age that is observed by or brought to the attention of a practitioner should be taken as a matter for inquiry. A satisfactory explanation should be sought.

A bruise must never be interpreted in isolation and must always be assessed in the context of development, personal, family and environmental history. The younger the child, the greater the risk that bruising is non-accidental and the greater the potential risk.

It is extremely rare for a non-mobile baby, for example one that is not yet crawling, to sustain accidental bruising.

Therefore all such bruising/injuries/marks/scalds in non-mobile babies/children should be viewed by practitioners as an indicator of possible physical abuse and, as such should be immediately referred to Children's Social Care Services and should be thoroughly investigated by Children's Social Care Services.

It should also be borne in mind that other unusual marks on the skin or unusual sites of bleeding for example bleeding from the mouth in young children or bleeding within the whites of the eyes may also be a sign of non-accidental injury and should also be referred to **Children's Social Care Services for investigation.**

All suspected or actual bruising, burns or scalds to babies/children who are not self-mobile should be subject to multi-agency investigation in order to assess the risk of harm. For this reason, any practitioner who identifies such an injury to a non-mobile baby/child is required to make a referral to **Children's Social Care**, regardless of the explanation offered by the carer givers, and regardless of the practitioner's own opinion about how the injury may have been caused.

A decision that a child has not suffered abuse must be a joint decision and must not be made by an individual or single agency.

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 area such as cheeks, around the eyes, ears, palms or soles. Remember non-mobile babies and children are unlikely to have bruised themselves accidentally.

Action to be taken on identifying actual or suspected bruising

An immobile baby/ child with bruising or another injury needs to be seen the same day by a Paediatrician. If the infant appears seriously ill or injured **seek immediate emergency treatment.**

There should be no delay in seeking medical attention including the baby / child attending hospital.

The practitioner should inform **Children's Social Care** of the concerns and of the child's location as soon as possible so they can commence child protection discussions e.g. Strategy Discussions and if required Section 47 Enquiries (England & Wales) Child Protection Order Section 37 (Scotland) & Child Protection enquiry / investigation (Northern Ireland).

Inform your Manager and the child's Social Worker.

- In all other cases where immediate emergency treatment is not required:
    - Record what is seen, using a body map or line drawing if appropriate (Appendix 01)
    - Record any explanation or comments by the parent/foster parent/adopter/ care giver word for word.
- Make a child protection referral immediately to Children's Social Care, who will take responsibility for arranging further multi-agency assessment.
- Inform your Manager and the child's Social Worker.

Practitioners should use their own professional judgement to determine if they need to stay with the child in order to maintain the child's safety.

It would be expected that, in most cases, the practitioner will inform the carer giver(s) of their intention to make a referral.

However, in judging whether or not to inform the carer giver(s) that a referral is to be made, the practitioner who has identified the suspected injury must consider the possibility that to do so may increase the level of risk to the baby/child.

If the practitioner concludes that informing the carer giver(s) may increase the level of risk to the baby/child, they should consult with Children's Social Care or the child's allocated Social Worker before speaking to the care giver(s) in order to obtain advice.

In all cases, Children's Social Care must be advised if the carer giver(s) is / are aware of the referral.

If the care giver is aware of the referral inform them of your professional responsibility to follow local Safeguarding Children Partnerships/ Boards/Committees procedures and that any action by Children's Social Care will be informed by a Paediatric assessment.

Children's Social Care must confirm that the information/referral has been received and is being acted upon by either the **allocated Social Worker** or **Team Manager**. If confirmation has not been received that the referral is being progressed within the same day then the Polaris practitioner should re-contact **Children's Social Care** to verify that the referral has been received by them and is being progressed.

Following a referral being made, a Strategy Discussion / Meeting will be held, at which a multi-agency decision will be made to consider if a child protection enquiry / investigation should be undertaken to determine if the baby/child has suffered harm.

In cases where information is received by **Children's Social Care** outside normal office hours, they will be required to begin the process of a conducting a Strategy Discussion.

It is not acceptable to allow the matter to wait until normal office hours have resumed.

All babies referred to Children's Social Care must have a medical assessment. The medical assessment should be carried out by a Paediatrician who will assess the injury to inform the

Strategy Meeting. This is the responsibility of Children's Social Care to arrange as part of a child protection investigation.

The Paediatrician should arrange for additional medical investigations if the circumstances warrant this. The Paediatrician will provide a verbal opinion at the time of the medical assessment, which will be followed up in writing within 72 hours, to Children's Social Care unless it has agreed that it will be sooner. If the child's Social Worker, upon receipt of the report, is unclear about the medical opinion, they must contact the Paediatrician to clarify this.

As a minimum, decisions should be made by a group consisting of Social Worker, Police Officer and Paediatrician.

Children's Social Care should also ensure that the outcomes of the enquiry are shared with the family/care giver(s) (unless to do so would place the baby and child at increased risk) and all relevant partners.

In all agencies, the outcomes of the enquiry should be recorded in detail. This is particularly important where a decision is taken that no further action is required to protect the baby or child.

See additional guidance and appendix below for 'Skin Map' for recording injuries (appendix 01).

Using professional judgement:

Professional judgement is based on your experience, training and role. However, it is important to remember that non-accidental injuries often occur in the same body areas as accidental ones, and professionals are often susceptible to accepting plausible explanations, especially if they feel they know the family well.

Be professionally curious:

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. See the below link which is an animated film, developed by a multi-agency partnership group led by a Designated Doctor for Safeguarding about professional curiosity:

Babies Who Don't Cruise Rarely Bruise

Recording actions:

Refer to the Monitoring and Notifiable Event Procedure for your agency for further actions to take and guidance on reporting the injury to the Inspectorates as required.

Additional actions:

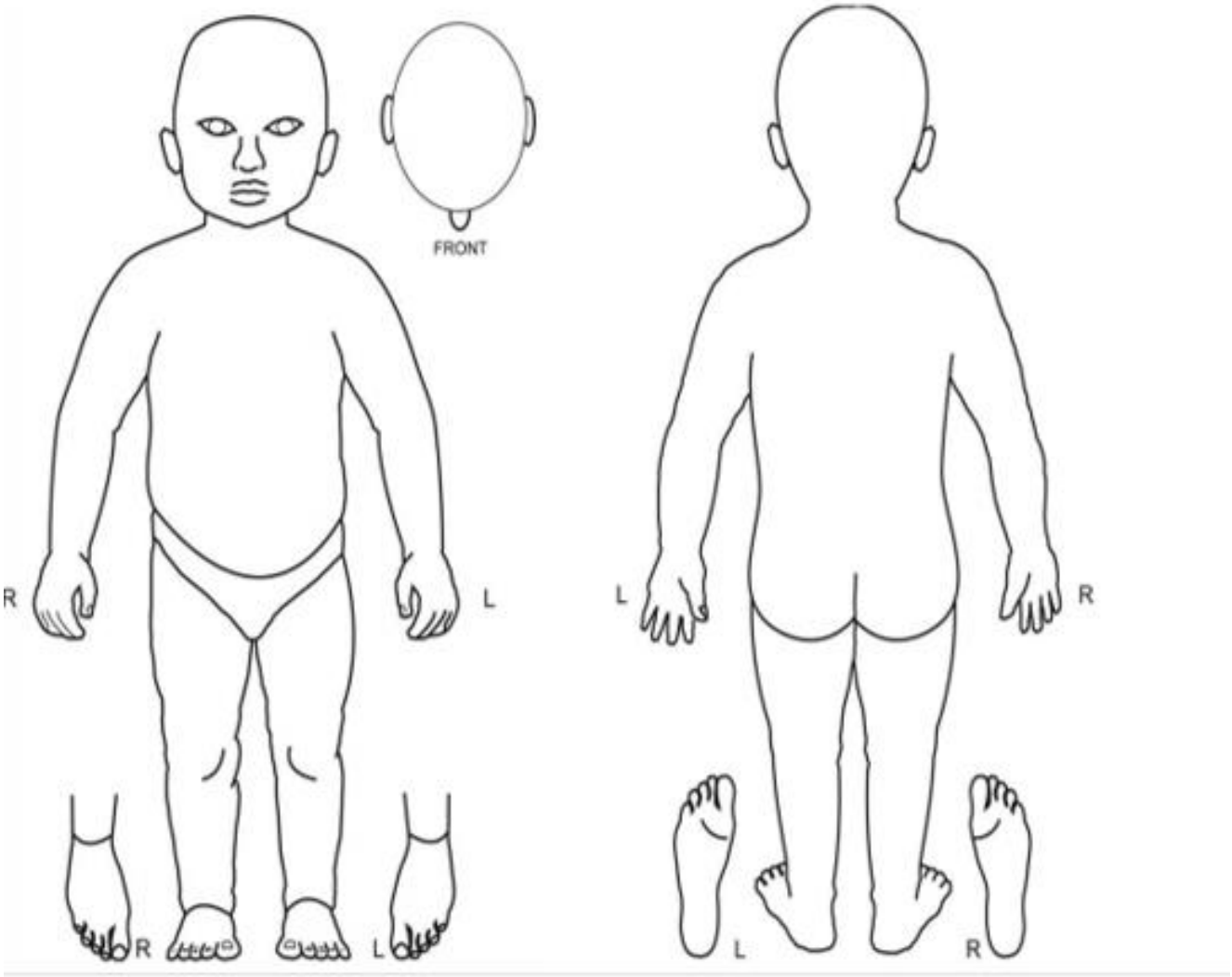
Once the immediate actions have been taken to safeguard the baby/child: if the incident is identified as meeting the threshold for a Serious Significant Event (SSE), the Registered Manager / Service Lead must inform the Responsible Individual, the Managing Director, Head of Quality Assurance and Safeguarding, Group Head of Safeguarding and the CEO as

appropriate in accordance with the Incident Reporting procedure and the Escalation and Crisis Communications Procedure.

Additional Guidance and Appendices:

Appendix 01

Skin map and box to record name and signature



Child's name:

Date of birth:

Date/time of skin markings/injuries observed:

Who the injuries were observed by:

Information recorded:

Date:

Time:

Name:

Signature:

References:

NHS https://www.cambridgeshireandpeterboroughccg.nhs.uk

NSPCC

Swindon safeguarding partnership

Barnsley safeguarding partnership

Bristol Safeguarding Board

Manchester Safeguarding Partnership

Bradford, Calderdale, Kirklees and Wakefield Safeguarding Children Partnerships

NICE Clinical guideline 89, Oct 2017. Overview | Child maltreatment: when to suspect maltreatment in under 18's

Maguire, S. (2010). Which injuries may indicate child abuse?

https://www.manchestersafeguardingpartnership.co.uk/resource/professional-curiosity-resources-practitioners/

Link to Local Safeguarding Children Partnerships/ Boards/Committees throughout the UK: Link to all UK Safeguarding Children Partnerships/Boards/Committees/