Leeds Safeguarding Children Partnership

Multi-agency Protocol for Bruising in Non-independently Mobile Children

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Contents

1. Introduction

What is this protocol? This protocol provides frontline staff with a knowledge base and action strategy for the assessment, management and referral of babies (or older children with a physical disability) who are Not Independently Mobile (NIM) who present with bruising or otherwise suspicious marks.

This protocol is the process by which a contact to Children Social Work Service (CSWS) should be made in tandem with Consultant Paediatrician, in order to consider what, if any, further assessment and investigations should take place. Within the hospital setting children should be referred directly to the Paediatric Medical Team, who will comprehensively assess the child, incorporating consultant paediatrician & social care opinions.

Why do we need this protocol? Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews and individual child protection cases across the UK have indicated that clinical staff have sometimes underestimated or ignored the highly predictive value, for child abuse, of the presence of bruising in young children who are not independently mobile (NIM). As a result there have been a number of cases where bruised children have suffered significant abuse that might have been prevented if action had been taken at an earlier stage.

Indeed the National Institute of Clinical Excellence guidance (NICE) Clinical Guideline 89 (2009, updated October 2017) states that bruising in any child not independently mobile should prompt suspicion of maltreatment (http://www.nice.org.uk/guidance/CG89)

Bruising is also the most common accidental injury experienced by children, and research shows that the likelihood of a baby sustaining accidental bruising increases with increased mobility. However, it is extremely rare (with a prevalence of less than 1% - Child protection companion; Royal College of Paediatrics and Child Health 2013) for a non-mobile baby, to sustain accidental bruising. **All such bruising therefore, should be suspected by professionals to be an indicator of physical abuse and should be thoroughly investigated. A decision that the child has not suffered abuse must be a joint decision and must not be made by a single agency.**

This protocol primarily deals with babies who are NIM, however it also provides guidance in relation to older children with a physical disability whom are also NIM, which is covered in section 5 of this multi-agency protocol.

In the light of the NICE guidelines "When to Suspect Child Maltreatment" (2009)[1] 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 all children with bruising who are not independently mobile be referred to CSWS (following the West Yorkshire Consortium guidelines and locally agreed LSCP procedures) and for a Consultant Paediatric opinion to be sought. Staff should not independently make decisions about how the injury occurred; however, any initial information gathered should be shared with the Paediatrician and with CSWS.

Who is this protocol aimed at? This protocol is aimed at all frontline staff who work with children and young people who are non-independently mobile, or families within which there are children and young people who are non-independently mobile.

2. Definitions and Terminology

Front-line practitioners: in line with "Working Together to Safeguard Children" (2015) this includes: teachers, GPs, nurses, midwives, health visitors, school nurses, early years professionals, youth workers, police, paediatricians, voluntary and community workers and social workers.

Not Independently Mobile (NIM): 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. Please note however that some babies can roll from a very early age and this does not constitute self-mobility. Consideration should be given to children with physical disabilities whom are also not independently mobile.

Bruising: Is the extravasation of blood in the soft tissues producing a temporary, non-blanching discolouration of the skin. This can be faint or small and with or without other skin abrasions or marks. Colouring may vary from yellow through green to brown or purple. This includes petechiae, which are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

Medical Bruising: bruising to very young babies may be caused by medical issues e.g. birth trauma however this is rare. In addition, some medical conditions can cause marks to the skin in very young babies that may resemble a bruise. An example of medical bruising is Mongolian blue spot (see Appendix 3 for further details) but this should be confirmed by a registered health professional and documented in the child's records. For other examples of medical bruising see
http://www.core-info.cardiff.ac.uk/reviews/bruising/patterns/other-useful-references

In all cases, unless the specific mark that has been identified is already confirmed by a health professional as arising from a medical condition, this protocol should be followed to enable multi-agency assessment of the suspected bruise.

[1] Please note that the above NICE guidance has been reviewed and is considered as still relevant. It will be reviewed again in 2019, and so therefore it remains valid.

3. Research Base

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 non-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.

In mobile children innocent bruises sustained due to accidents such as a result of exploring their environment 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 of the hands or soles of the feet.

Infants under 1 year are over three times as likely to have child protection plans for physical abuse as children over 1 year. Almost half of all serious case reviews involve a child less than 1 year old.

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

Also see http://www.core-info.cardiff.ac.uk/reviews/bruising/patterns/patterns-and-sites-abused

A bruise must never be interpreted in isolation and must always be assessed in the context of medical & social history, developmental stage, explanation given and this should be shared with the Paediatrician. A full clinical examination and relevant investigations must be undertaken.

The younger the child the greater the risk that bruising is non-accidental, 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 P, 2008). They should seek an explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history. However, it must be borne in mind that there have been many serious case reviews in which carers have offered “satisfactory explanations” and the child has turned out to have been physically abused. History from the caregivers is only one piece of the jigsaw in all areas of child protection. In fact the NICE guidance on when to suspect child maltreatment states, “Do not rely solely on information from the parent or carer in an assessment.”

4. Contacts to Children Social Work Services (CSWS) and Paediatric Opinion

Non-Healthcare Staff: This protocol requires any front-line practitioner who identifies a potential bruise to a baby who is not yet self-mobile to make a contact to CSWS. This is because there is a significant possibility that the bruising may have arisen as a result of abuse or neglect.

Healthcare Staff: Any Healthcare professional who identifies a potential bruise to a baby not yet independently mobile should seek the advice of another health professional and the decision to make a contact should be undertaken jointly with another professional or senior colleague.

When a decision to make a contact is decided it is the responsibility of the first professional who observed the bruising to make the contact. However, this requirement should not prevent an individual professional of any status contacting CSWS with regards to any child with bruising who in their judgement may be at risk of child abuse.

Contacts to CSWS: Contacts to CSWS should be made in line with the local procedure, including gaining consent from the parents, unless there is a clear increased risk to the child by doing so. However a contact should still be made if parents do not consent in order to safeguard the child.

Professionals should also consider the needs of other children in the family who may be affected and inform CSWS in order that a strategy discussion gives proportionate consideration to the possible need for child protection medical examinations of other children in the family.

If the family are already known to CSWS then the front-line practitioner should inform the named Social Worker as soon as is possible.

Paediatric Opinion: When a child is referred to CSWS under this protocol, CSWS should undertake a referral to the Community Paediatric Department for an assessment of the bruise or mark and a detailed physical examination of the child (Child Protection Medical).

Note: This excludes children in accident and emergency, or within the hospital setting, where cases should be referred directly to the Paediatric Medical team, who will comprehensively assess the child, incorporating Consultant Paediatrician & social care opinion.

For a paediatric opinion contact:

- During office hours (8.30am – 5.00pm): Tel: 0113 843 2001
- At all other times: Call the on-call Paediatrician for the hospital (Tel: 0113 2432799) and ask switchboard to bleep the ‘on-call paediatrician’.

The Consultant Community Paediatrician must liaise with CSWS with regard to the outcome of the assessment as soon as it is completed.

The contact should be made, and the child seen, on an urgent and immediate basis. If necessary a social worker should assist the family to get to the assessment.

It is expected that all contacts to CSWS (and notification to any existing Social Worker) under this protocol, will be responded to and assessment commence, on the same day that the request is received.

Where a contact is delayed for any reason, or where bruising is no longer visible, a Consultant Paediatrician must still examine the child to assess, as a minimum, general health, signs of other injuries or pointers to maltreatment, and to exclude bleeding disorders.

5. Bruising in Non-Mobile Older Children eg a child with a disability

Recent studies of bruising patterns in disabled children showed that the dorsum of the feet, thighs, arms, hands and trunk are sites of unintentional bruising. This is thought to be due to knocks during transfers, bumps from wheelchair users or ill-fitting / misuse of equipment. Where appropriate parents / carers should be provided with support and information in relation to the use of correct equipment. Bruising to the hands, arms and abdomen were significantly more common in disabled than able-bodied children. Bruising increases with increasing independent mobility.[2]

Bruising which occurs on an immobile older child will not automatically require a contact to Duty and Advice, however the pattern of bruising should be considered in the context of the child's development with specific care taken not to explain away the bruises because of health needs, health care or disability without careful checking.

Consideration should be given to repeat patterns of bruising and whether this might be indicative of non-accidental injuries. Practitioners should be open to the possibility that a child with a disability could potentially be harmed deliberately, and that there may be many underlying factors as to why this may be.

If a practitioner is identifying bruising within a non-independently mobile older child they should, along with others forms of assessment with regards to what they see, consider the following:

- Does the explanation for the bruise match the child's developmental capability and likely behaviour?
- Was the child developmentally capable of causing these injuries to him or herself?
- Does this pattern of bruising match the particular developmental capabilities of a child of this age with these particular developmental needs?
- For a child who is otherwise meeting developmental milestones, might a parental explanation for injuries be too readily accepted?
- Is there a full understanding of the caregiving the child receives?

When considering children with complex health and physical disabilities, front line practitioners must, with parental consent, include staff in specialist educational provision and Children's nurses and or inclusion nurses, who may be currently supporting the child and as such hold important information as to what the daily life of the child is like.[3]

If following conversations with parents / carers and other professionals as appropriate a practitioner feels that a child or young person is suffering, or at risk of suffering harm they should contact Duty and Advice in line with the local procedure, including gaining consent from the parents, unless there is a clear increased risk to the child by doing so. However a contact should still be made if parents do not consent in order to safeguard the child.

Professionals should also consider the needs of other children in the family who may be affected and inform CSWS in order that a strategy discussion gives consideration to the possible need for child protection medical examinations of other children in the family.

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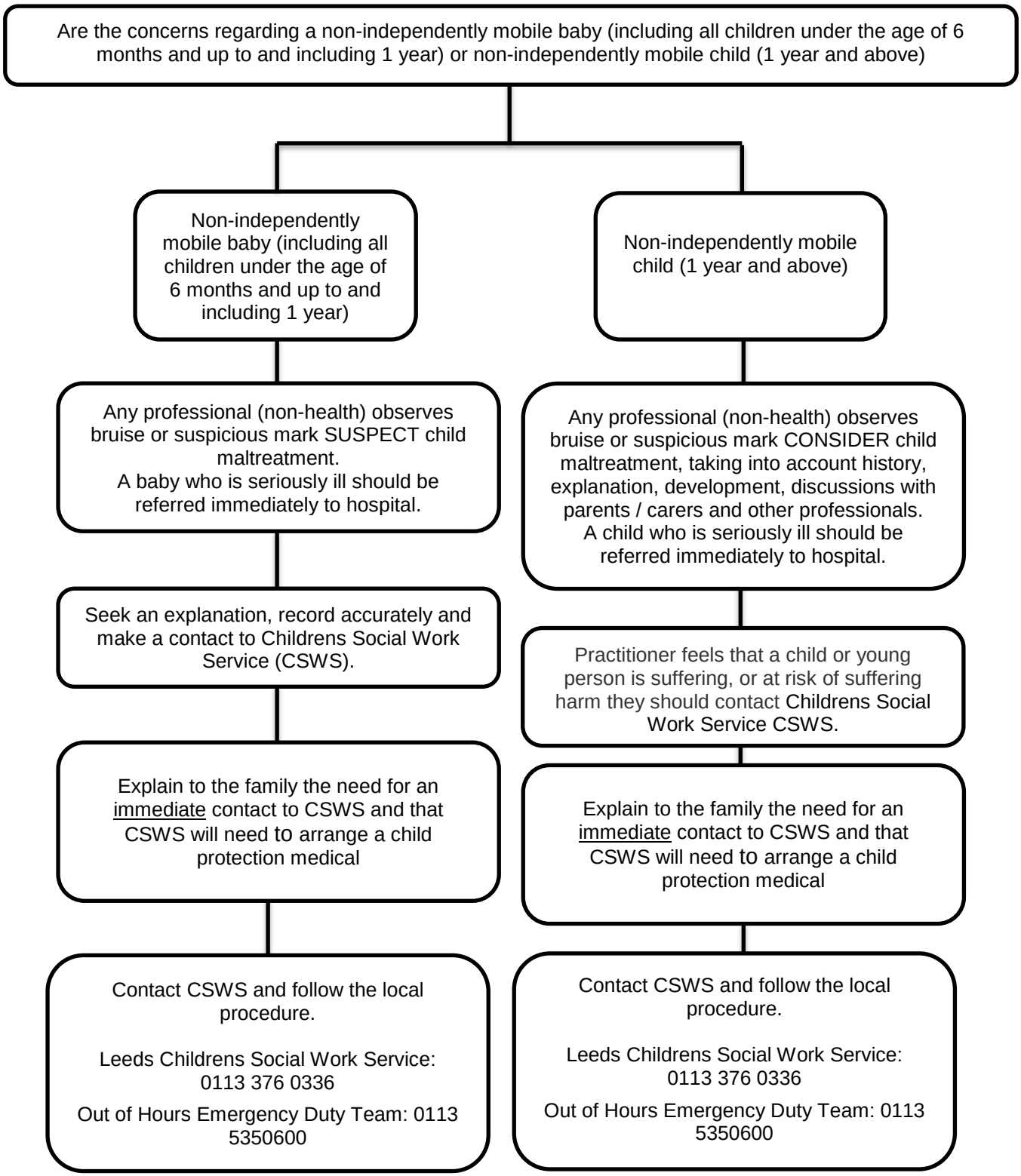
[2] Child protection Companion, Royal College of Pediatrics and Child health, 2013 9.3.15-9.3.17

[3] Research Report DFE-RR110 - Child and family practitioners' understanding of child development: Lessons learnt from a small sample of serious case reviews

Appendix 1

Assessment of bruising and other possible injuries in non-independently mobile* babies and children

(Non-health practitioner)

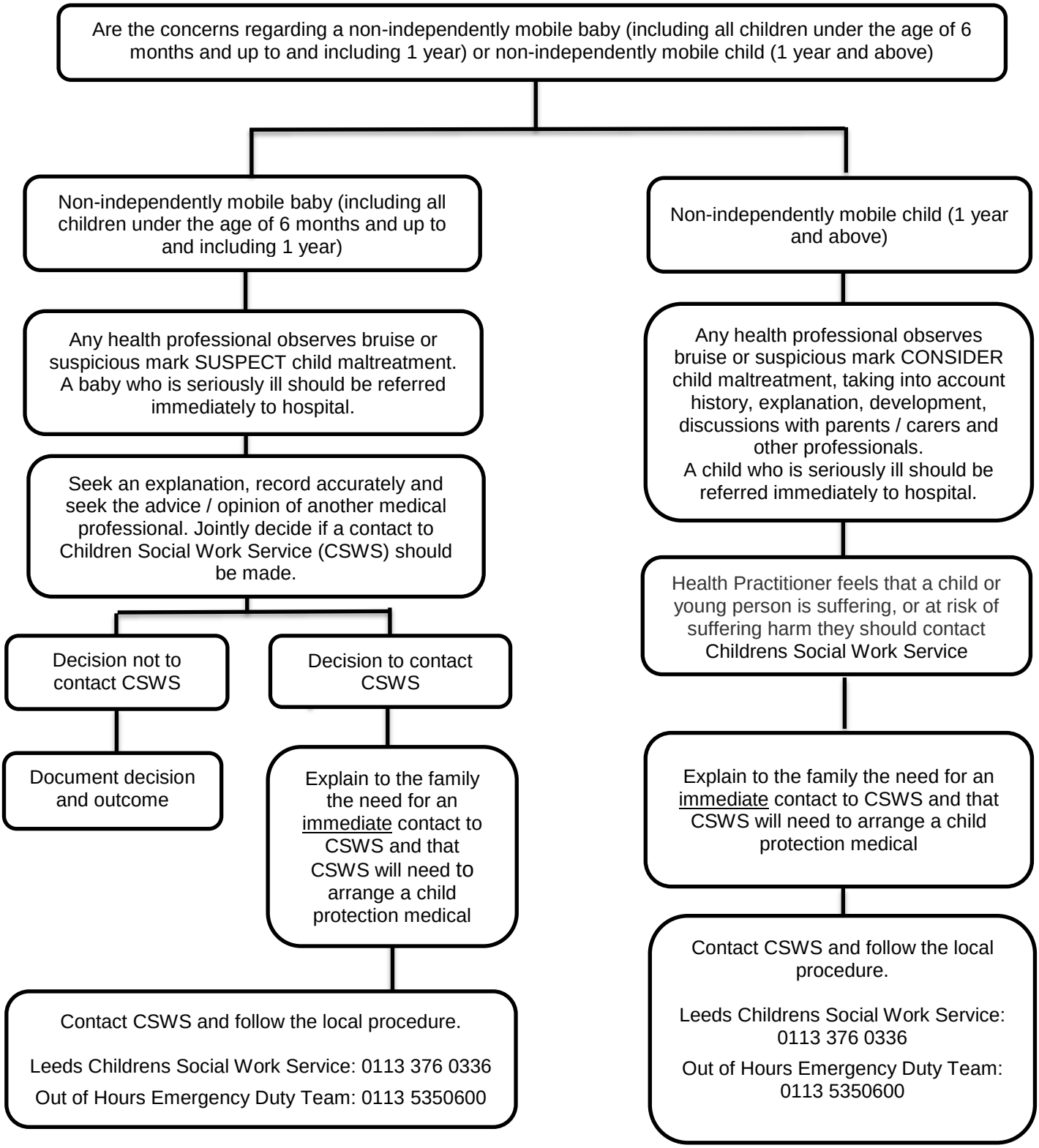


** not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently, this includes all children under the age of six months. Please note however that some babies can roll from a very early age and this does not constitute self-mobility.*

Appendix 2

Assessment of bruising and other possible injuries in non-independently mobile* babies and children

(Health practitioner)



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Appendix 3

Mongolian Blue Spots

Mongolian Blue Spots are hyper pigmented areas usually seen at birth or in early life. They can sometimes look like bruises.

Unfortunately issues around birth marks including Mongolian Blue Spots have led to a small number of families being subjected to contacts to CSWS being placed, resulting in inappropriately significant distress and inconvenience.

Any Mongolian blue spot marks discovered at birth by midwife / obstetrician / paediatrician need to be clearly recorded in both the baby's and maternity notes.

What are Mongolian Spots?

- Hyper pigmented skin areas
- Usually seen at birth or early life
- Common in children of Asian/African decent
- Rarer in Caucasians
- Usually bluish/slate-grey in colour
- Usually flat and not raised, swollen or inflamed
- Usually round/ovoid but can be triangular, heart-shaped or linear
- Can be single or multiple marks
- Usually on the lower back/sacrum/buttocks
- Trunk, extremities (rare)
- Face or scalp (extremely rare)
- Usually fade with age

Differentiation Mongolian Spots from Bruising

- Typical sites
- Non-tender
- Usually homogeneous in colour
- Don't change colour and take months/years to disappear
- Must always document presence of Mongolian spots, including how extensive, site and shape.

(refer to photographs for examples)

Carer Guidance / Information regarding the Safeguarding Assessment & process is available here (or a hard copy is available from Leeds Teaching Hospital Trust). Health practitioners may find this information useful for discussion with parents.

Appendix 2 Carer Guidance.pdf

Pathway of care regarding suspected birth mark / Mongolian Blue Spots

Practitioner observes a mark on a child

Practitioner is confident that it is a birth mark of some type including Mongolian Blue Spots

Practitioner thinks it is likely that it is a birth mark or Mongolian Blue Sport but is not sure.

Practitioner is concerned that it may be a bruise rather than birth mark or a Mongolian Blue Spot

ACTION:
Check Medical / Health Records to see if mark has been recorded previously. If it has been recorded no further action required.

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Check Medical / Health Records to see if mark has been recorded previously. If it has been recorded no further action required.

ACTION:
Follow the multi-agency policy for the Assessment of Bruising in Non-Mobile Babies & Children; child will require Child Protection Medical examination by Paediatrician; Refer to Children's Social Care

If not recorded, record mark/s in child health records and inform GP of the finding.

If there is no record of the mark, Health Visitor or Midwife to discuss with GP.

GP Assessment*

GP sees child and is certain it is a birth mark / Mongolian Blue Spot, informs the Health visitor or Midwife by phone. GP documents it on the System1 or Emis template.

GP sees child, is not sure about mark, or is concerned it may be a bruise; GP calls back the practitioner who will initiate a referral to Childrens Social Work Services.

***GP Assessment –**
If the GP feels unable to offer an appropriate opinion (eg. no GP available with regular paediatric experience), then after discussion, the HV or Midwife makes a direct referral for acute paediatric review (via PCAL – 0113 2065996). The principle is to resolve whenever possible promptly within primary care, while recognising that relevant expertise may not always be available.
This referral route is only to be used in the specific case of uncertainty about a possible birthmark or Mongolian Blue Spot.

Baby has been brought for an assessment by a consultant paediatrician at LTHT to determine / rule out a bruise.

Consultant Paediatrician determines it is not a bruise; discharges child back to primary care if medically well and no other safeguarding concerns.

Consultant Paediatrician is unclear about the presentation, CP medical examination to be undertaken with a referral to CSWS.