Pan-Dorset Safeguarding Children Partnership

PAN-DORSET PROTOCOL FOR NON-MOBILE INFANTS AND CHILDREN PRESENTING WITH ACTUAL OR SUSPECTED INJURIES

VERSION CONTROL

VERSION NUMBER	REASON FOR REVIEW	AUTHOR	DATE
1.0		Wendy D'Arrigo, Designated Doctor for Safeguarding, NHS Dorset	July 2021
2.0	Recommendation in National Panel Guidance (September 2022)	Sue Kirkley, BCP Interim Business Manager	November 2022
3.0	Addition of link to Siblings in Medical Examinations (section 6)	Wendy D'Arrigo, Designated Doctor for Safeguarding, NHS Dorset	April 2023
4.0	Next review due		November 2023
5.0			
6.0			

1. Introduction:

Injuries in non-mobile infants or children are unusual although occasionally they do occur. They must never be interpreted in isolation. There are two separate risks that need to be considered, firstly the clinical significance of any injury sustained and secondly the potential safeguarding risk inherent in the situation. While the clinical risk may be low e.g. an isolated bruise with no other injury, the safeguarding risk may be high and needs careful evaluation. Serious case reviews (now known as child safeguarding practice reviews – CSPR) locally and nationally have identified cases where there was an undue reliance on the medical assessment and a lack of curiosity about the broader family situation. This can result in children being left in situations of high risk.

The assessment must be multiagency**. A decision that the child has not suffered abuse must be a joint decision and must not be made by an individual or single agency**. Assessment should include a full medical, developmental and social history. The child must be fully undressed during the examination. Particular concern should be noted if:

- The history is inconsistent with the injury or the child's development
- The history is inconsistent over time, vague or based on supposition about "what must have happened"
- There are repeated incidents of injury

2. Definitions:

- **Non-mobile**: Any infant or older child with a disability who is unable to crawl or pull to stand. Being able to roll but not crawl is considered as non-mobile but the ability to roll may be relevant in some scenarios e.g. a baby rolling off a surface. A detailed account of what happened is needed and must be compared with the child's developmental abilities.
- **Injury:** bruise or other suspicious skin marks, bleeding including from the nose or mouth, fractures which may present with swelling or reduction in movement of the affected limb, burn or scald, suspected head injury with irritability, fits or altered consciousness.

3. Aims of protocol

The protocol provides guidance for the referral, assessment and management of any nonmobile child where an injury is known or suspected.

4. Target audience

All staff in Dorset, Bournemouth, Christchurch and Poole whose work brings them into contact with children.

5. Action to be taken on identifying actual or suspected injury in a non-mobile child:

While the guidance recognises that practitioner's professional judgement must be always exercised it errs on the side of robust risk management.

5.1 If the child appears seriously ill or injured

5.1.1. Seek emergency treatment at an emergency department (ED) calling 999 if needs be.

5.1.2 Notify children's social care (CSC) of your concerns and the child's whereabouts.

5.2 In all other cases (except as stated in 5.3 below)

5.2.1 Record what is seen on a body map or using a line drawing (appendix 2).

5.2.2 Record word for word any explanation or comments provided by the parents or carers.

5.2.3 Refer to children's social care (CSC). Telephone referrals must be followed up in writing. CSC will assume responsibility for organising the multiagency assessment. A child protection medical assessment will be requested via a strategy discussion between social care, police and paediatrics. This may be held face to face or virtually. The timing of the medical assessment will be agreed at the strategy discussion but if it is not to be held immediately the safety of the child and any siblings in the interim will need to be considered. In general children should be seen on the day of referral or within 24 hours if referred out of hours.

5.3 In the specific situation of a child being presented directly to the ED by the parent or carer and the presenting complaint is the injury or trauma that is reported to have caused the injury.

5.3.1 A full history must be taken with a word for word record of any explanation or comments made by the parents or carers about what has happened.

5.3.2 the child must be fully undressed and examined for evidence of current or past injury and any other medical conditions.

5.3.3 investigations and treatment must be arranged promptly as clinically indicated.

5.3.4 the child must be examined by a senior Emergency Department Doctor. (ST4 or above). If there is uncertainty about the cause of the injury or suspected non-accidental injury the child must also be seen by a senior paediatrician.

5.3.5 in all cases risk factors for possible abuse within the household should be considered and children's social care must be contacted by the assessing clinician to find out if there are any known risk factors. Social care must record if no action is to be taken by their agency and this must also be documented in the medical record.

5.3.6 if after review and discussion between senior clinicians, non-accidental injury is suspected a referral must be made to children's social care for multiagency assessment. The child should be admitted to a paediatric ward.

5.3.7 if the injury is considered to be accidental, to not require admission for treatment and the child is discharged home the discharge summary should be shared with the GP and health visiting service (or school nurse for older children who are non-mobile). The summary must include adequate information about the injury, the assessment, and the reasons for the conclusion.

6. Siblings in child protection medical examinations procedure

Please see link to this procedure here Siblings in Child Protection Medical Examinations procedure

7. Action following referral to children's social care

7.1 Children's services will arrange a strategy discussion with paediatrics and the police to consider the need for a medical assessment (unless already done as in 5.3) and the appropriate timing.

If it is a social worker that identifies the mark in question and is confident that it is due to an injury a strategy discussion should be convened as above. If the social worker is not sure if it could be a birth mark or an indicator of illness, they should seek an opinion from the GP in the first instance.

7.2 Following the strategy discussion if a medical assessment is deemed necessary the child must attend. The assessment should include a detailed history from the parent or carer about what has happened; a review of the past medical history and family history including any previous reports of injury; and an enquiry about vulnerabilities within the family. The child must be fully undressed for examination. The paediatrician should explain the findings of the assessment to the parents. In some cases, the information shared with parents may need to be agreed beforehand with the police.

7.3 There must be a further strategy discussion between children's social care the paediatrician and police if non-accidental injury is likely. The paediatrician must give an opinion about the possibility of non-accidental injury on the balance of probabilities considering the assessment of risk and protective factors identified. This must be considered in light of other health information available e.g., from the GP, social care and police records. The paediatric opinion should be given verbally and immediately in writing (initial conclusion form available via both DCH and Poole hospital child protection teams). The multiagency professionals should consider if the injury is likely to be accidental, nonaccidental or inconclusive (see appendix 3). A decision must be made regarding the need for medical investigations and an immediate safety plan for the child and any siblings must be agreed. The outcome of the discussion must be explained to the parents.

8. Specific considerations:

8.1 Birth injury: Both normal birth and instrumental delivery may lead to bruising and bleeding into the white of the eye which will appear red. Fractures may also occur. However physical abuse may occur within the hospital setting and if there are any concerns that the injury may not be related to the birth this protocol should be followed. Some birth injuries become more apparent over the first few days or weeks e.g. the callus of a healing clavicular fracture or a hard rim developing in a cephalohematoma (bleeding in the scalp that calcifies during healing).

8.2 Birthmarks: These may not be visible at birth and may appear in the early weeks or months. Mongolian blue spots may look like bruising. They are rare in Caucasian children but very common in children from African, Middle Eastern, Mediterranean or Asian backgrounds. If they are noted, it is important that their size and shape are recorded to avoid possible future confusion. They do NOT need to be referred for assessment. Where

a practitioner believes a mark seen is a birthmark but not is not certain they should seek advice from a senior colleague or the GP who should see the child on the same day. Parents should be asked if they have photographs of their baby from the first day or so of life as these may clearly show any birthmarks. If there is still uncertainty a referral should be made to children's social care under this protocol. If the GP is not certain about a mark, they may seek a 2nd opinion from a paediatrician. The child must be seen the same day. If the paediatrician identifies an injury a referral must be made to social care. A full child protection medical assessment will be needed.

8.3 Skin conditions: some skin conditions may look like a bruise or a burn. The child may be unwell, but this is not always the case. If the practitioner is in doubt, they should seek advice from the GP who should see the child on the same day. A GP may seek a 2nd clinical opinion from a paediatrician but if there is any significant concern about possible nonaccidental injury a referral should be made to children's social care under this protocol and a child protection medical assessment will then be arranged. If the paediatrician sees the child for a 2nd opinion and thinks the mark is likely to be an injury a referral must be made to social care under this protocol.

8.4 Self-inflicted injury: It is very rare for non-mobile infants to injure themselves although e.g. sucking injuries are sometimes seen. Suggestions that an injury has been caused by a child hitting themselves with a toy or against the bars of a cot should not be accepted without detailed assessment by a paediatrician and social worker. Police involvement in the investigation may be helpful.

8.5 Injury caused by other children: It is unusual but not unknown for children to be injured in this way. The child must be referred under this protocol for further assessment which must include a detailed history of the circumstances of the injury and the parents' or carers' ability to supervise their children.

8.6 Babies with prolonged or persistent crying warrant further assessment. There are many possible medical causes for this and there may not be any significant underlying cause, but the differential diagnosis includes non-accidental injury. Prolonged crying is also a risk factor for abuse, particularly non-accidental head injury. New-born babies commonly cry for approximately 2 hours per day and crying is usually at its highest level in the first 3-4 months. Crying for more than 3.5 hours per day is generally considered to be high. Even normal crying may be distressing and difficult for parents to cope with.

8.7 Children who are disabled: Disabled children are at increased risk of non-accidental injury and many will be unable to give an account of what happened. Injuries most commonly involve bruising, but other injuries may occur including a visible swelling or a reduction in limb movement compared to the child's normal pattern of movement. Disabled children may also be at increased risk of injury because of malnourishment or neuromuscular problems e.g. muscle spasms and may sustain spontaneous injuries as a result. Many children have very specific moving and handling needs, and injuries can be sustained accidentally in relation to the use of equipment. It is important that any injury noted should be recorded on a body map. For school aged children these should be shared with the school nurse and for younger children with the health visitor. Patterns of bruising need to be considered in the context of the child's environment and equipment but if there is any concern that the injury may be non- accidental or due to rough handling a referral for assessment should be made under this protocol.

9. Evidence base:

9.1 Bruising is the commonest presenting feature of physical abuse in children. Research shows that bruising is highly correlated with mobility and bruising in non-mobile children is uncommon (2.2% of babies who are not yet rolling)[1.] Careful assessment of children who are non-mobile is therefore crucial. (Rolling needs careful definition and therefore for the purposes of this protocol rolling is not considered to indicate mobility but the child's development will need to be carefully assessed in relation to the history of the injury.)

9.2 National Institute for Clinical Excellence (NICE) guidance July2009[2]

http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English

This gives guidance as to when to consider non-accidental injury within a differential diagnosis or when to suspect i.e. there is a high level of concern. Professionals should SUSPECT maltreatment if:

- If a child has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement
- If there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition e.g. a bleeding disorder and if the explanation for the bruising is unsuitable e.g.
- Bruising in a non-mobile child
- multiple bruises or bruises in clusters
- bruises of a similar size and shape
- bruises on non-bony body parts
- bruises on the neck that look like attempted strangulation
- Bruises on the wrists and ankles that look like ligature marks • One or more fractures in the absence of a medical condition predisposing to fragile bones
- Burns or scalds in a non-mobile child.
- Intracranial injury in a child if there is no major confirmed accidental trauma or known medical cause in one or more of the following circumstances:
- there is an absent or unsuitable explanation
- the child is under the age of 3 years
- there are also other inflicted injuries, retinal haemorrhages or rib or long bone fractures
- there are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage to the brain.

Professionals should CONSIDER maltreatment if:

- Bleeding from the nose or mouth (especially in an infant who has an apparent life-threatening event) and a medical explanation has not been identified.

10. References

1. Kemp A.M., Dunstan F., Nuttall D. et al. Patterns of bruising in preschool children – a longitudinal study. Arch dis Child 2015; 100: 426-431

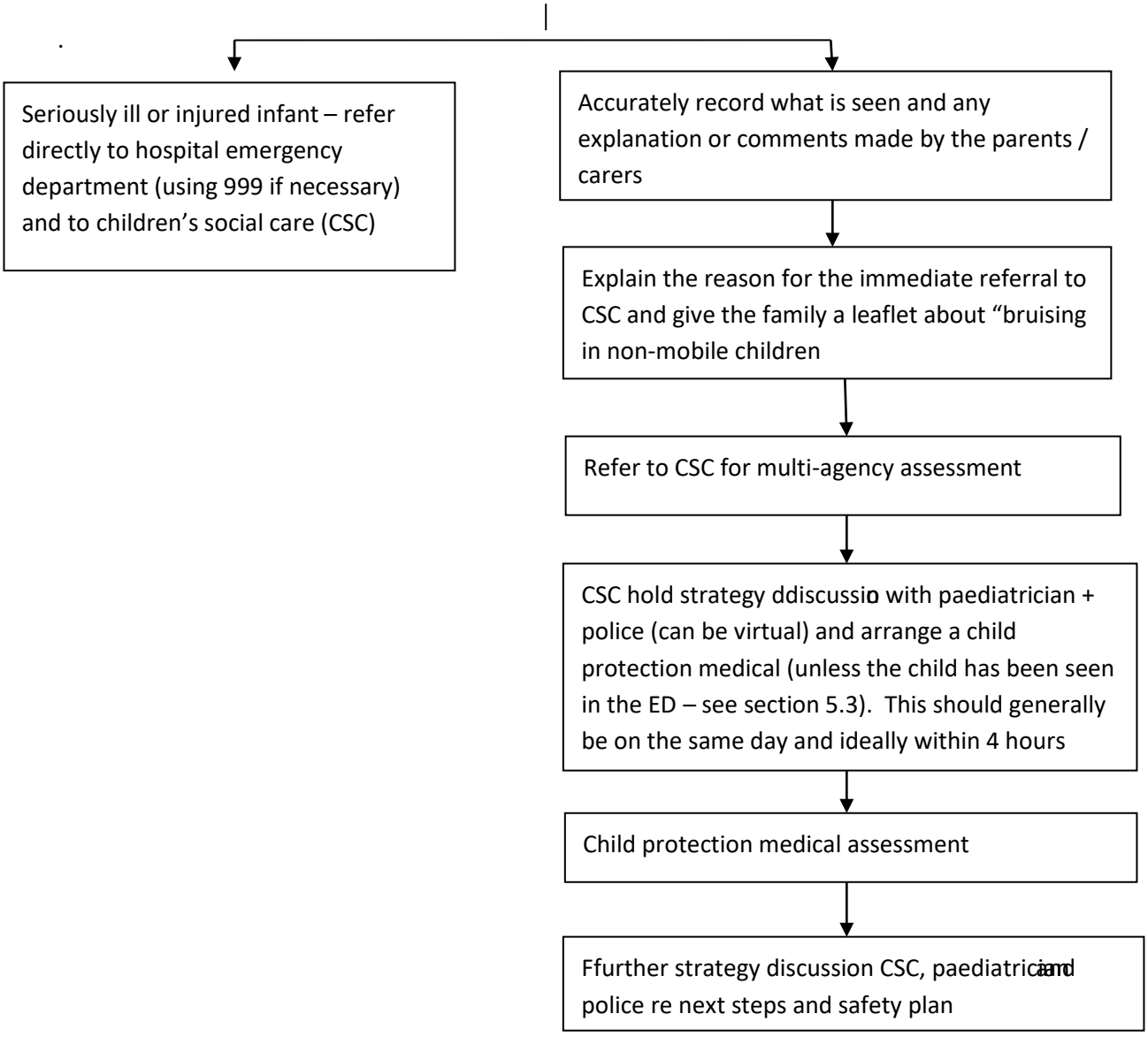
2. When to suspect child maltreatment, NICE clinical guideline 89, July 2009

3. https://www.rcpch.ac.uk/key-topics/child-protection/evidence-reviews Royal College of Paediatrics and Child Health (RCPCH) child protection evidence (previously known as Core Info Cardiff Child Protection systematic reviews

4. Pathways to harms, pathways to protection: a triennial analysis of serious case reviews 2011 – 2014. DfE, May 2016.

Appendix 1: Flow chart for referral process for injuries in non-mobile children

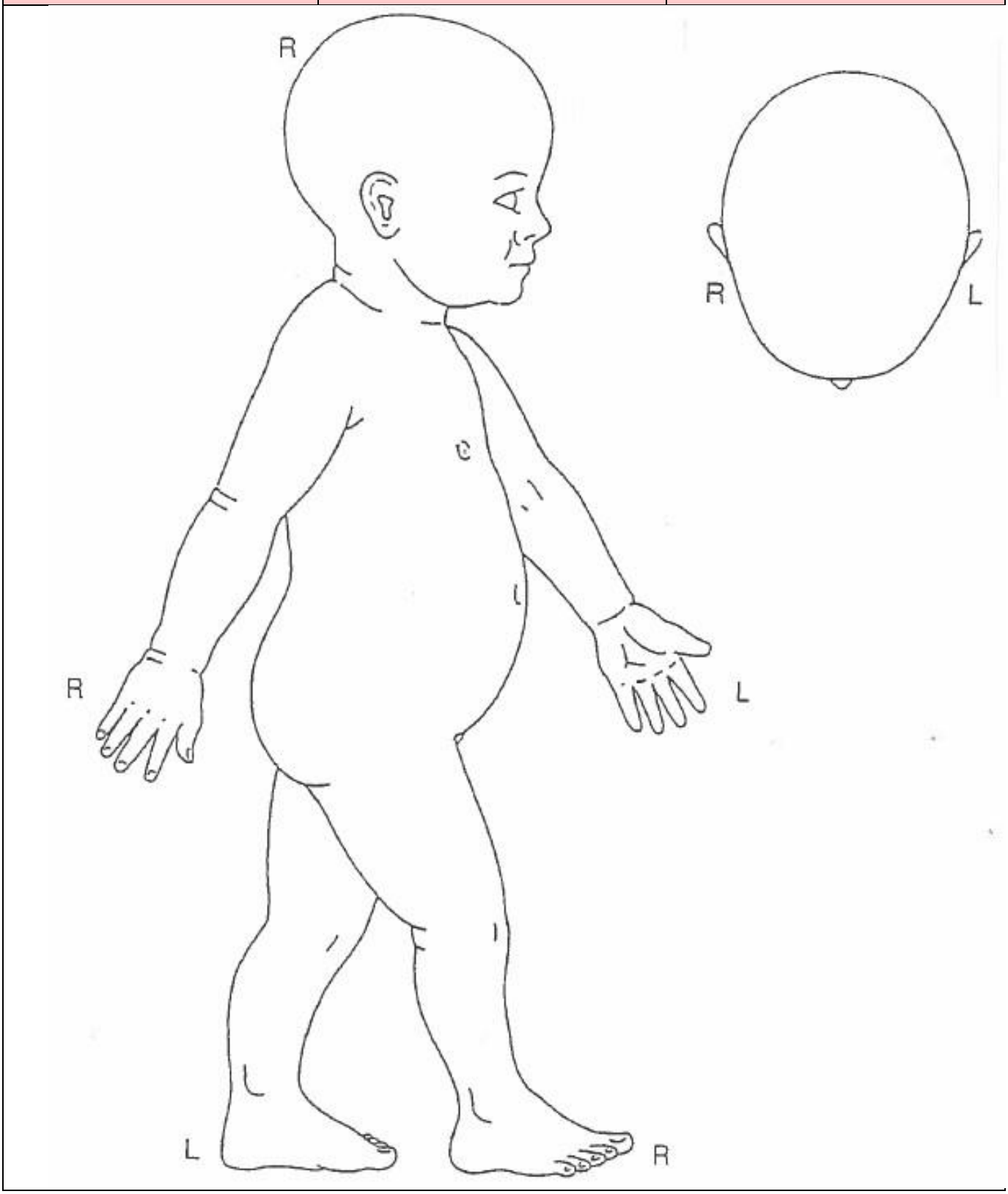
Practitioner observes a bruise or injury in non-mobile child suspect child maltreatment



Contact numbers for CSC	**Dorset**	**Bournemouth, Christchurch and Poole**
Office hours	08:00 – 22:00 Mon – Fri 09:00 – 22:00 Sat - Sun	08.30-17.15 Mon - Thurs 08.30-16.45 Fri
Office hours	01305 228866 Professionals: 01305 228558	01202 123334 Health professionals only: 01202 794209
Out of office hours	01305 228866	01202 738256

APPENDIX 2: BODY MAPS

Child's Name:	DoB:	Hospital No:
Date of Exam:	Examiner:	Signature:



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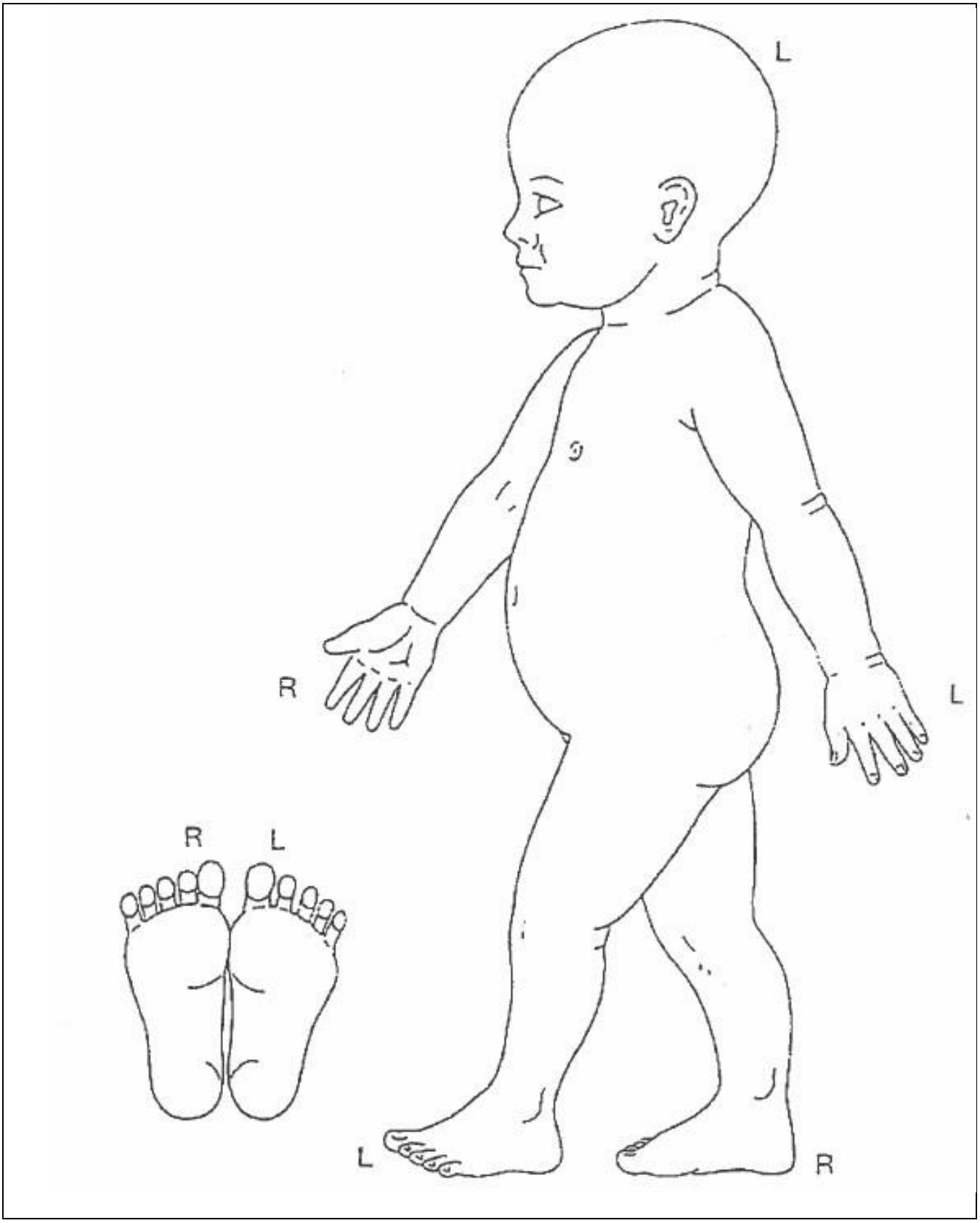

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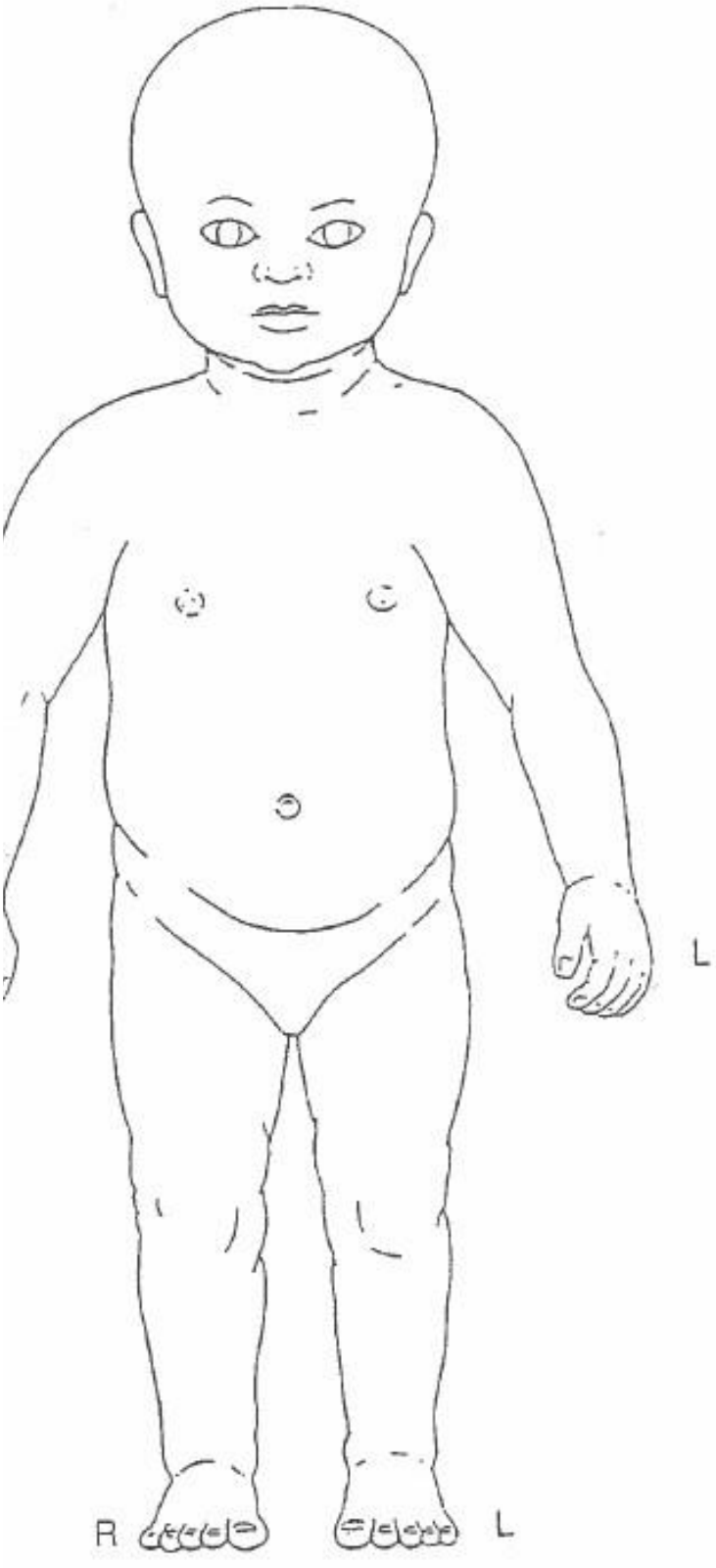

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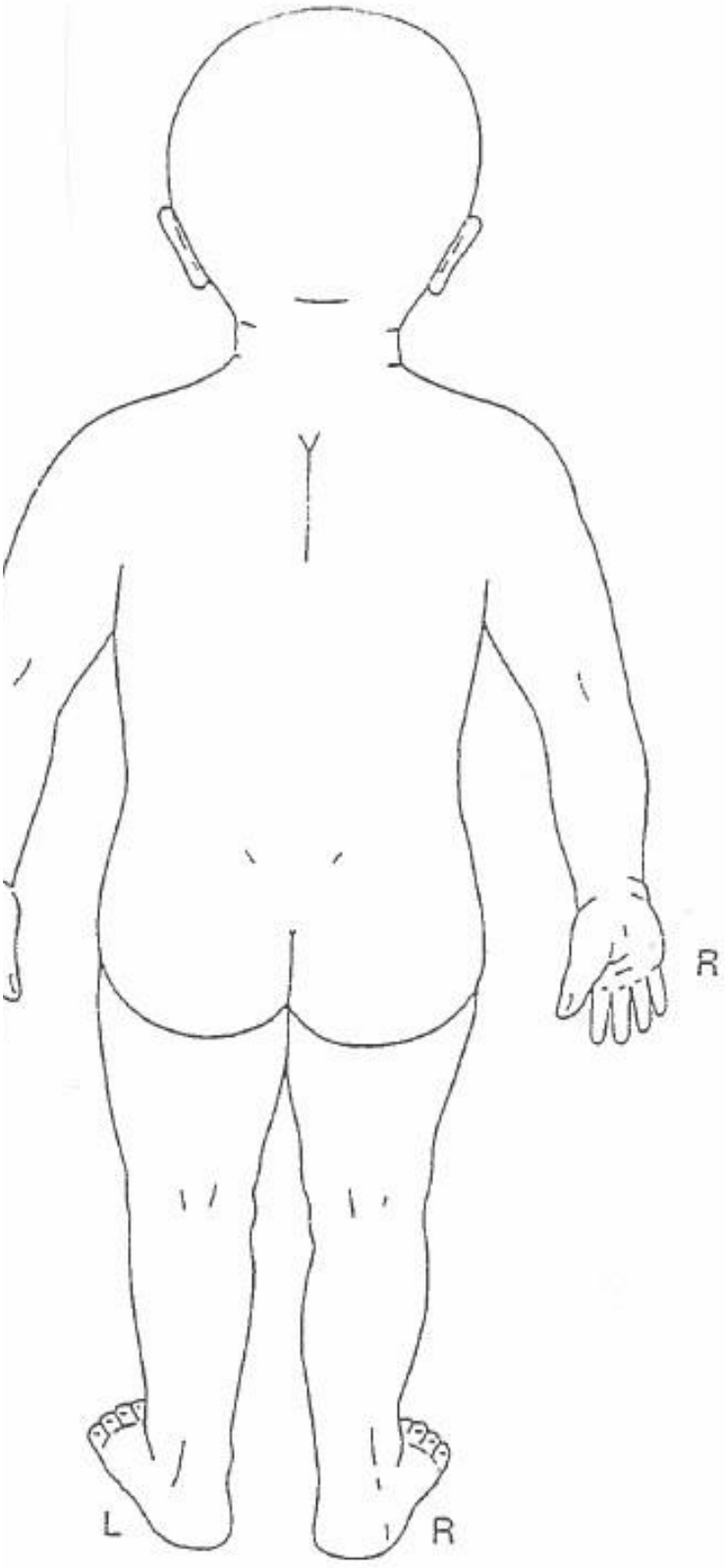

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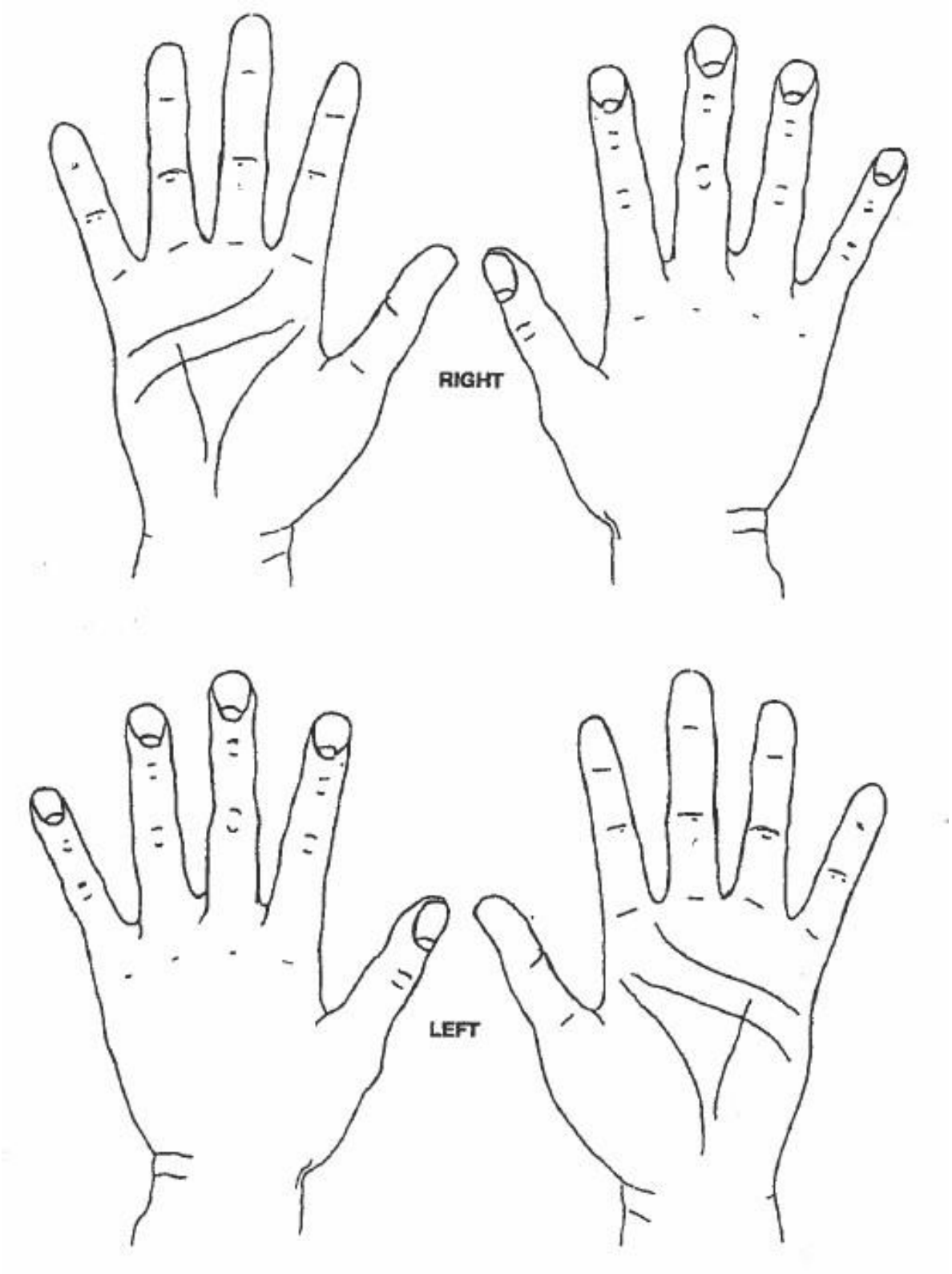
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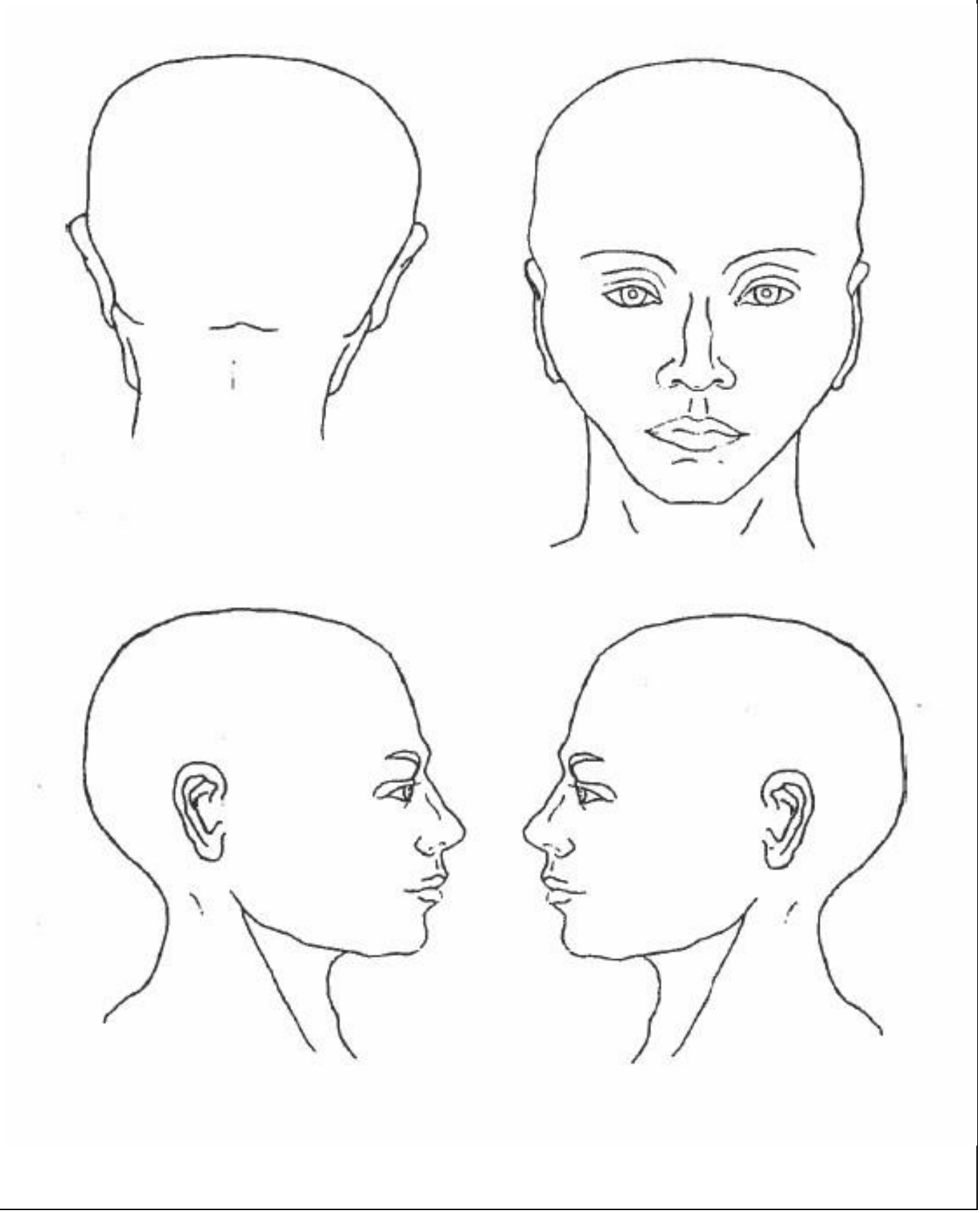
Child's Name:	DoB:	Hospital No:
Date of Exam:	Examiner:	Signature:



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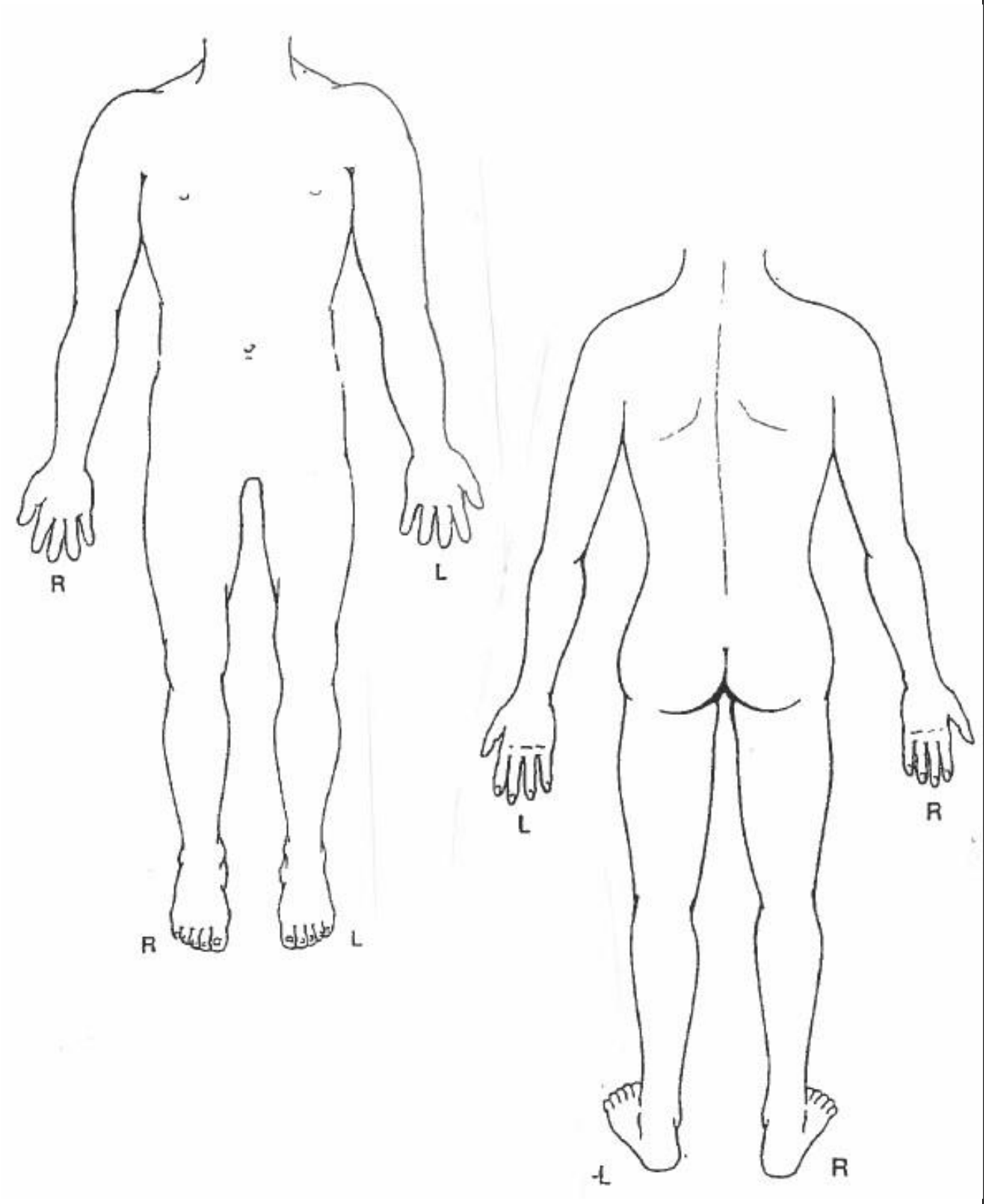

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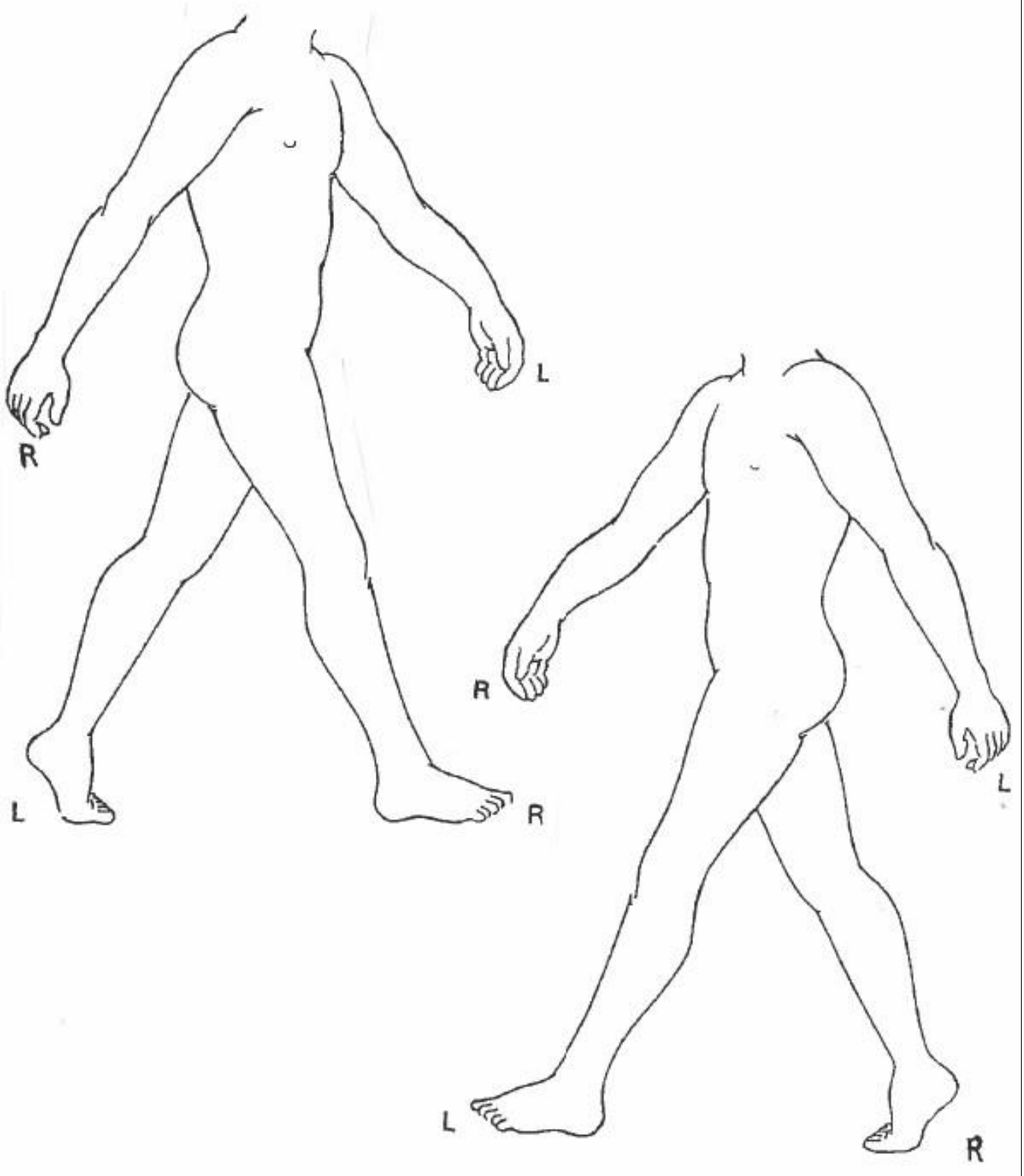

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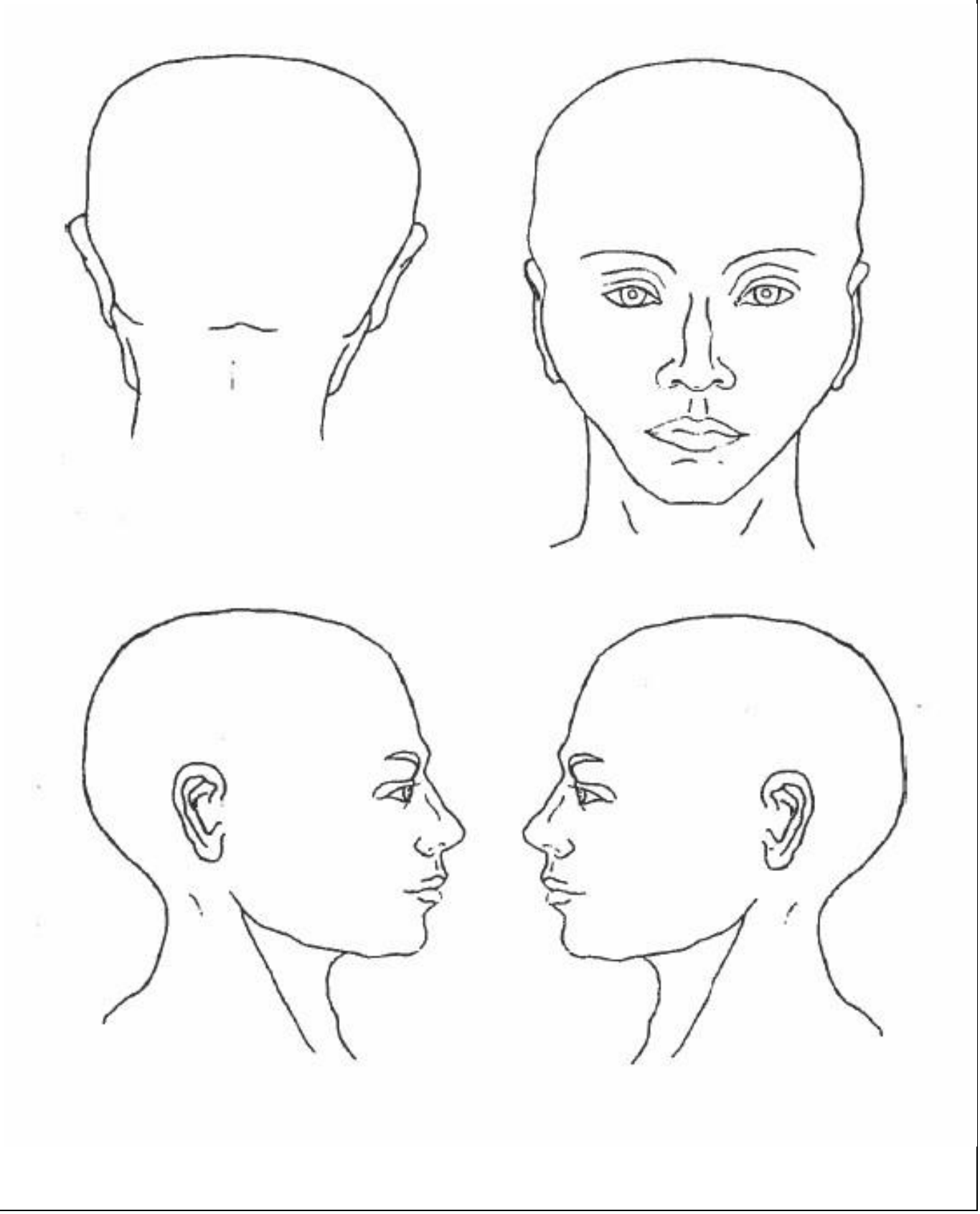

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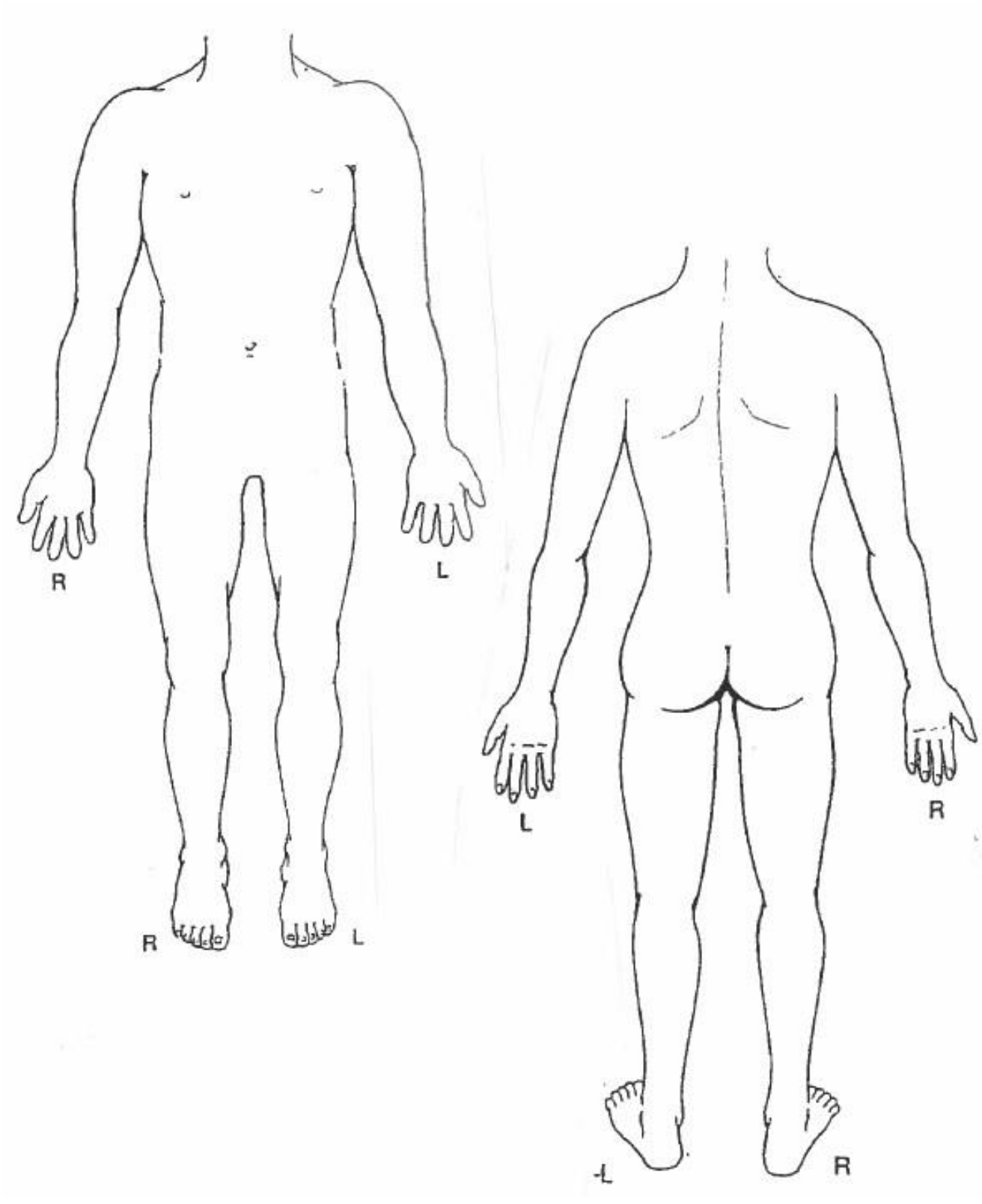

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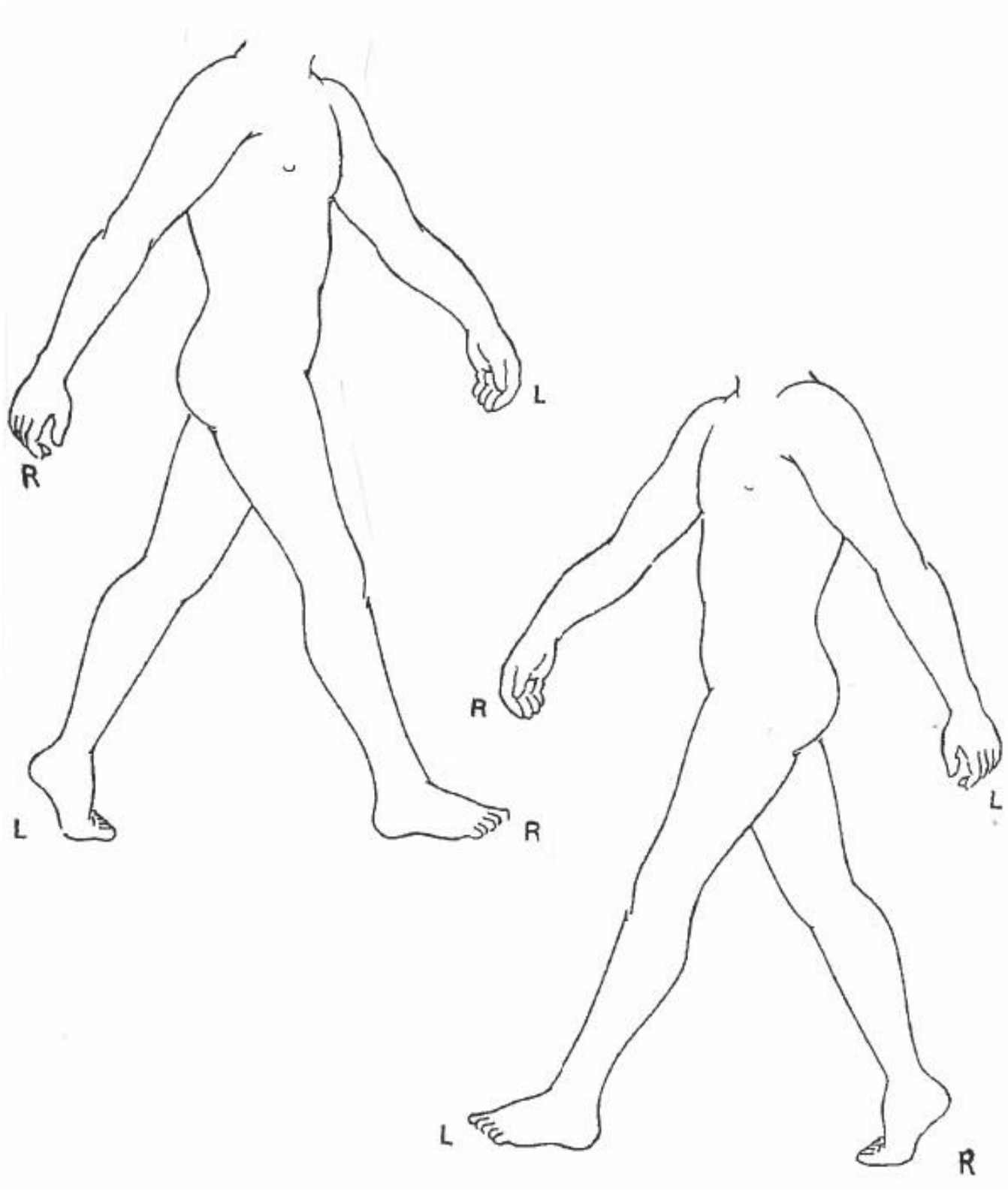

Appendix 3 - Categories of injuries to aid decision making about investigations and next steps

When an injury is identified the aim of the assessment is to establish how it was sustained and what the on-going risk to the child and family is.

Accidental: A clear and consistent account of a plausible mechanism where there is no other identified concern including on background checks. The history is consistent with the examination findings and the child's developmental level. Independent witness accounts may be available to support the history. These children are often presented directly to the emergency department. In these cases, there may be no need for further assessment. It is good practice to consider seeking a 2nd opinion from another senior clinician before reaching this conclusion.
Discuss with CSC for background checks. Consider if any further assessment or treatment is indicated. Health Visitor follow up (or school nurse for older disabled non-mobile child).

Non-accidental: from the history and / or the examination it is clear, that the injury could not have been sustained accidentally. These children will, in most cases, need further medical investigation (CT head, skeletal survey and eye examination) and a full multi-agency investigation. In the case of an older disabled child a clinical decision will need to be made as to what, if any medical investigations are indicated.

Inconclusive: this is a common situation. An injury is present, and an explanation is provided but there is some doubt as to whether the injury could have been sustained in that way e.g. could it have happened as described without rough handling or excessive force being applied? In these cases, multiagency assessment led by social care and including a strategy discussion involving police colleagues is crucial for understanding potential risks and may aid decision making about the need for further medical investigations including radiological examination.

Flowchart 2: Injuries including bruises in non-mobile infants and children: guidance re assessment for doctors, social workers and police

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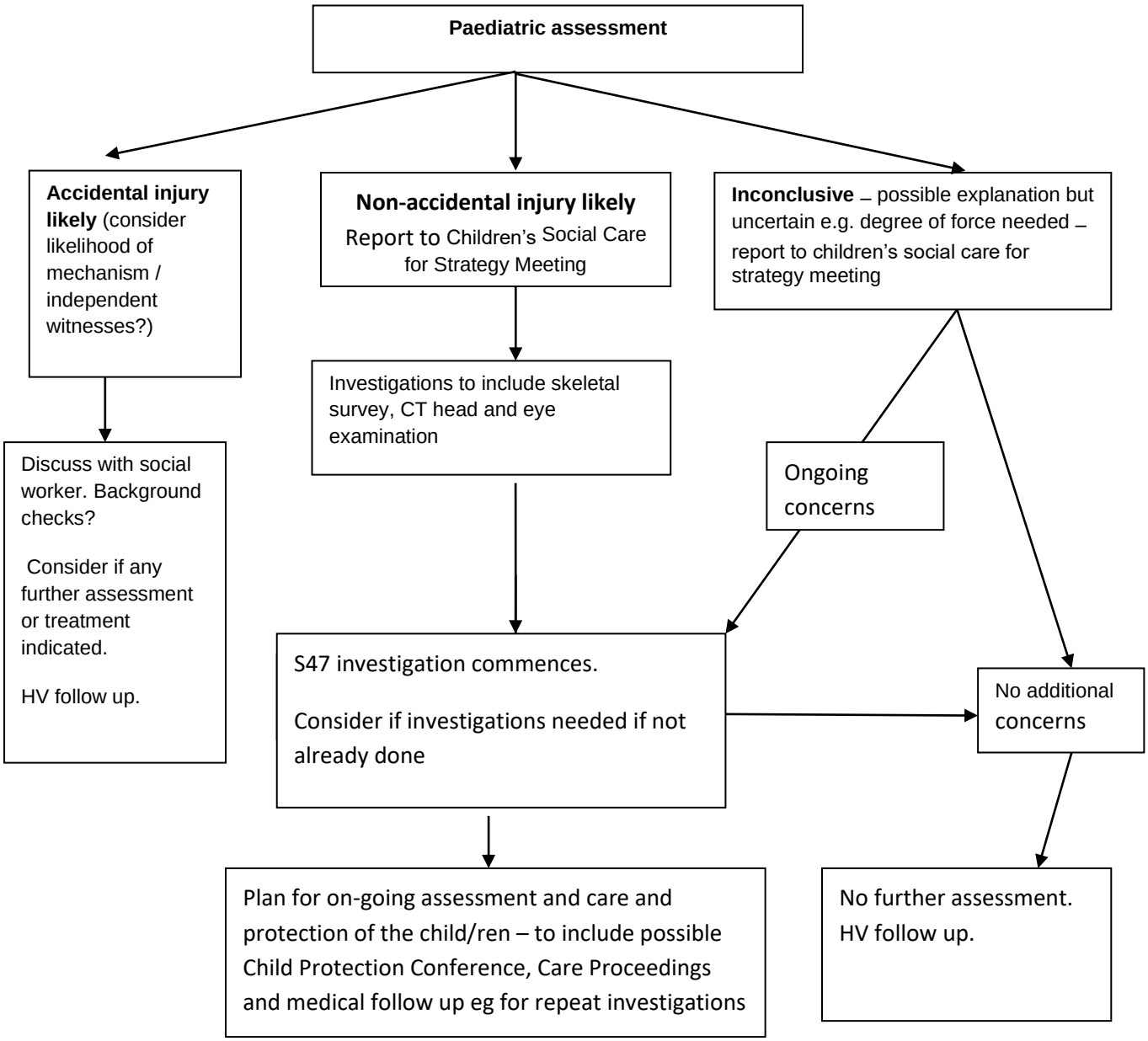
Paediatric assessment
Accidental injury likely (consider likelihood of mechanism / independent witnesses?)
Non-accidental injury likely
Report to Children's Social Care for Strategy Meeting
Inconclusive – possible explanation but uncertain e.g. degree of force needed – report to children's social care for strategy meeting
Investigations to include skeletal survey, CT head and eye examination
Discuss with social worker. Background checks?
Consider if any further assessment or treatment indicated.
HV follow up.
Ongoing concerns
S47 investigation commences.
Consider if investigations needed if not already done
No additional concerns
Plan for on-going assessment and care and protection of the child/ren – to include possible Child Protection Conference, Care Proceedings and medical follow up eg for repeat investigations
No further assessment.
HV follow up.