Pan-Dorset Safeguarding Children Partnership

DORSET POLICE

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

VERSION CONTROL

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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	Annual review	Sophie Cole, Dorset Business Support Manager	April 2024
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6.0			

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1. Scope:

This is a Pan-Dorset, multi-agency joint protocol, which particularly applies to National Health Services, Children's, Early Years, Adult Social Care Services and Police across Dorset and Bournemouth, Christchurch, and Poole (BCP) Local Authority areas. It should be read following reference to the core safeguarding procedures which can be found here Contents (proceduresonline.com). This protocol is aligned with the Working Together to Safeguard Children (2023) statutory guidance.

2. Target audience:

All practitioners working across Dorset, Bournemouth, Christchurch, and Poole Local Authority areas whose work brings them into contact with children. The agencies most likely to identify an actual or suspected injury to a non-mobile infant or child and be involved in the multi-agency response to these concerns, are Midwifery, Health Visiting, Acute Hospital, Primary Care, Early Years, Children's Services, Adult Services, and the Police.

3. Aim of the protocol:

The protocol provides guidance for the referral, assessment, and management of any non-mobile child where an injury is known or suspected. The protocol also provides guidance for scenarios where a parent or carer may report that a non-mobile infant or child has experienced physical harm, either deliberately or accidentally, but there is no visible bruise or injury to the infant or child.

4. The national definitions are as follows:

- **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.

5. 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 of physical harm to them.

There is a flowchart which outlines the procedure for practitioners to take on identifying actual or suspected bruising or injury to a non-mobile baby or child.

6. Recognition and identification of bruising or other injury:

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.

6.1 Consideration of non-accidental injury:

Given that accidental bruising or injury to a non-mobile infant or child is rare, you should always consider the possibility of an actual or suspected bruise or injury being an indicator of child abuse. You should maintain a high level of professional curiosity in cases where non-mobile infants or children present with a bruise or injury. This should, however, be considered in the context of:

- Social history of the family and any known vulnerabilities of the parents/carers e.g. domestic abuse, any history of violent behaviours, mental health issues, neurodiversity, or substance misuse.
- Any previous agency involvement with the family.
- Any other previously reported bruises or injuries to the infant or child.
- The infant or child's stage of development.
- The explanation of the bruise or injury provided by the parents/carers and their response to the bruise or injury.
- Any supporting evidence that the bruise or injury is a birthmark/birth injury/medical condition. Although, just because a mark on a child may be documented as a birthmark/birth injury/medical condition, this does not mean that any new mark that might appear on the child is not the result of non-accidental injury.

Recent Child Safeguarding Practice Reviews completed locally have highlighted learning in relation to professionals not appropriately assessing and responding to concerns where a parent/carer has reported to Children's Services that a non-mobile infant has accidentally been physically harmed. If it is concluded as an accidental injury, then professionals should consider whether the family require further support. For example, the parent/carer may be under stress and so a referral to Early Help services and follow up advice and guidance provided by a health professional, should be considered.

The National Institute for Clinical Excellence (NICE) guidance July2009[2] Recommendations | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE sets out guidance as to when to consider non-accidental injury within a differential diagnosis or when to suspect child maltreatment 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 there is:

- 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.

6.2 Consideration of other causes of bruises or injuries:

It can sometimes be difficult to distinguish between a bruise or injury and another mark to the skin, such as a birthmark. If the bruise or injury does not appear to fit the criteria outlined in the NICE guidance above in 6.1, then you should consider the possibility that it could relate to one of the scenarios listed below (starting from 6.2.1). Sometimes it may only become clear that a mark is a bruise if it fades over time; a bruise will fade over time, whereas a birthmark will usually stay the same colour and shape. Where there is doubt about the nature of the mark, then you should ensure that the infant or child is kept safe until clarification is sought.

If you suspect that the bruise or injury could relate to one of the below scenarios listed in 6.2.1, 6.2.2 or 6.2.3, then you should seek evidence to support this. This could be through consulting the child's Red Book, which should detail any birth marks or injuries that were recorded at birth, or consulting with the GP to examine the child's medical records.

6.2.1 Birth injury: Normal birth, caesarean section or 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).

6.2.2 Birthmarks: These may not be visible at birth and may appear in the early weeks or months. Congenital dermal melanocytosis (formerly known as 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 on a body map (so that the location on the body is noted) 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 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 (CSC) under this protocol. Please follow the core child protection procedures. 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 children's social care. A full child protection medical assessment will be needed.

6.2.3 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 on the same day 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 children's social care under this protocol.

6.2.4 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.

6.2.5 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.

6.3 Other Specific Considerations:

6.3.1 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. Please refer to ICON guidance.

6.3.2 Children who are disabled: Disabled children are at increased risk of non-accidental injury, and some 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.

7. Action to be taken on identifying, or receiving reports of an actual or suspected injury on a non-mobile child:

The flowchart outlines the procedure that practitioners should take on identifying, or receiving reports of, an actual or suspected bruise or injury in a non-mobile infant or child.

While the guidance recognises that practitioner's professional judgement must be always exercised it errs on the side of robust risk management. If it is still not clear from consulting the child's Red Book and/or the GP, and you still have concerns that the bruise or injury is not medically related, then you should follow the guidance from 7.2.6 below.

7.1 If the child appears seriously ill or injured:

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

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

7.2 In all other cases (except as stated in 7.2.16 below)

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

7.2.2 Record word for word any explanation or comments provided by the parents or carers. You should ask the parents or carers for a full detailed medical history of the child.

7.2.3 Firstly, you would want to rule out if the suspected or actual mark or injury is the result of a birthmark, birth injury or medical condition. As noted above, you should consult the child's Red Book to see if there were any evidence that would show that this is the result of one of these things. You could also consult the child's GP to check their medical records. You could also ask to see any photos that the parent/carer has of the child as a newborn baby that identifies any marks, as these will be timestamped. If you are not sure that this is a birth mark or injury, then please follow the guidance from 7.2.6.

If it is still not clear from consulting the child's Red Book and/or the GP, and you still have concerns that the bruise or injury is not medically related, then you should follow the guidance from 7.2.6 below.

7.2.4 If there is evidence to support the fact that the suspected or actual bruise or injury is the result of a birthmark, birth injury or medical condition, then you should ensure that the appropriate medical professional is made aware of the discussion e.g. the GP, obstetrician, Midwife, or Health Visitor. Please then record the outcome of your discussion in your agency's case notes. If you have no further concerns around the child's safety and wellbeing, following evidence being provided that the mark or injury seen is as a result of a birthmark, birth injury or medical condition, then no further action should be taken.

7.2.6 As referred to in section 6.1, you may receive a direct report from a parent or carer to say that their child has accidently been physically harmed but there may not be a visible bruise or injury. In these circumstances, you should follow the guidance from 7.2.7 below.

7.2.7 If you have concerns/evidence that the suspected or actual bruise or injury to the non-mobile infant or child is not related to a birth mark, birth injury or medical condition, then you should refer to Local Authority Children's Social Care Front Door. You should be informing parents/carers unless you think this puts child at risk (please refer to Information Sharing (proceduresonline.com).

The Pan-Dorset Safeguarding Children Core Procedures sets out that:

When sharing information about a child or family with Children's Social Care, it is good practice for practitioners to be transparent about their concerns and to seek to work cooperatively with parents or carers. Practitioners should therefore usually inform parents or carers (and the child depending on their age and level of understandings) that they are going to make a referral.

However, referrals can be made without first informing parents or carers when to do so would place a child at risk.

Where a practitioner makes a referral without informing the parents or carers this must be recorded in the child's file with reasons and confirmed in the referral to Children's Social Care.

If you are unsure, please consult with an appropriate manager. The referral should consider the areas outlined in 6.1 above, such as the social history of the family and any previous involvement with CSC. It may be identified that further information is required to be able to determine the next steps to be taken.

7.2.8 Based on the referral to CSC Front Door, they may decide that a strategy discussion is required. CSC will assume responsibility for organising the multi-agency assessment and this will involve a social worker, a paediatrician, MASH Health, and the police.

7.2.9 If a strategy discussion is not deemed necessary, following referral to the CSC Front Door, then you should consider any follow up actions required and seeking consent from parents/carers to access further support where required (see Information Sharing (proceduresonline.com). Actions could include, follow up visit to the parents or carers by the Health Visitor, Midwife, GP, or Obstetrician, or a further assessment by CSC for child in need or whether a referral to Early Help is required. If there is doubt remaining that this is an accidental injury, and where there may still be safeguarding concerns, then a strategy discussion must always be held.

7.2.10 If a strategy discussion is deemed appropriate, the parents or carers will need to understand why a referral has been made and that a strategy discussion is being held (unless this would put the child at risk of harm). They should be provided with a leaflet on bruising and injuries to non-mobile infants or children (this would normally be provided by the referrer).

7.2.11 The strategy discussion is held to consider whether a child has or is likely to suffer significant harm, and these questions should be considered:

- Does the bruise/injury fit any of these criteria set out by NICE (2009) from the perspective of the practitioner who observed the bruise or injury and from multi-agency assessment? Consider the presentation of the bruise or mark.
- Does the parent/carer offer a clear and consistent explanation for the bruise or injury and does this align with the child's age and stage of development? Did the parents/carers proactively report the injury or was this identified incidentally through a routine check-up, for example? Are there any independent witnesses to corroborate the account provided by the parents/carers?
- Is there any known history of involvement by agencies with the family and are there are any known vulnerabilities of the child and/or family?
- What is the current lived experience of the child and family – is there particular stress for the parents/carers? What is the child saying happened (if applicable)?
- Has there been any other previously reported injuries to the child and/or their siblings?
- Could this injury be deliberate, or the result of neglect or lack of parental supervision e.g. has a sibling caused harm to the child?
- What does the behaviour of the child tell us? Are they showing signs that they have been subjected to possible abuse or neglect? What are the interactions between child and parent/carer like?

The strategy discussion will explore as far as possible the full medical, developmental, and social history of the child and family. A key decision to be made is whether a child protection medical examination is required and the timing it should be completed (unless already done so as part of 7.2.16). The meeting will decide whether section 47 enquiries are required.

7.2.12 There may be professional disagreement regarding whether a child protection medical assessment is required. The local resolution and escalation procedure should be adhered to in those circumstances. Non-mobile infants and children are extremely vulnerable to a serious outcome from physical abuse and so it is important that the safety of the child is maintained whilst a decision is reached.

7.2.13 If the meeting agrees that section 47 enquiries are required, then the child protection procedures regarding section 47 enquiries should be followed. 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. Please refer to the siblings in child protection medical examinations procedure.

7.2.14 Following the strategy discussion, if a medical assessment is deemed necessary the child must attend. The medical 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. 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.

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.

7.2.15 The parents/carers should be informed of the outcome of the strategy discussion. **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**. There should be a follow up to the child by an appropriate health professional e.g. GP, Obstetrician, Midwife or Health Visitor and advice and guidance offered to the parents/carers. Consideration should be given to whether the child may be a child in need or whether a referral to Early Help is required. The outcome should be recorded in the agency’s case notes.

7.2.16 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:

7.2.17 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.

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

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

7.2.20 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.

7.2.21 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.

7.2.22 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.

7.2.23 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.

8.Action to be taken following the child protection medical examination:

8.1 There should be information sharing between agencies following a child protection medical examination and if required, a further strategy discussion could be considered.

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).

8.1.1 The multi-agency professionals should consider if the injury is likely to be accidental, nonaccidental or inconclusive (see appendix 3). The assessment must be multi-agency**. 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**.

8.1.2 If the injury is determined to be likely non-accidental, then 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. If the injury is determined to be accidental or inconclusive but there are still ongoing concerns for the safety of the child, then a safety plan must be put in place for the child and siblings, and any next steps agreed e.g. holding a child protection conference.

8.1.3 If the injury is determined to be accidental and there are no ongoing concerns for the safety of the child, then there should be an appropriate follow up to the parents or carers by a medical professional e.g. GP, Obstetrician, Midwife, or Health Visitor to offer advice and guidance. Consideration should be given to whether the child may be a child in need or whether a referral to Early Help is required. The outcome should be recorded in the agency's case notes.

8.1.4 In all cases, the outcome of the strategy discussion must be communicated to the parents or carers and the referrer.

9. References and Further Information

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.

5. **Bruising in non-Mobile Infants (Child Safeguarding Review Panel)**

6. Information Sharing (proceduresonline.com)

7. Referrals (proceduresonline.com)

8. Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)

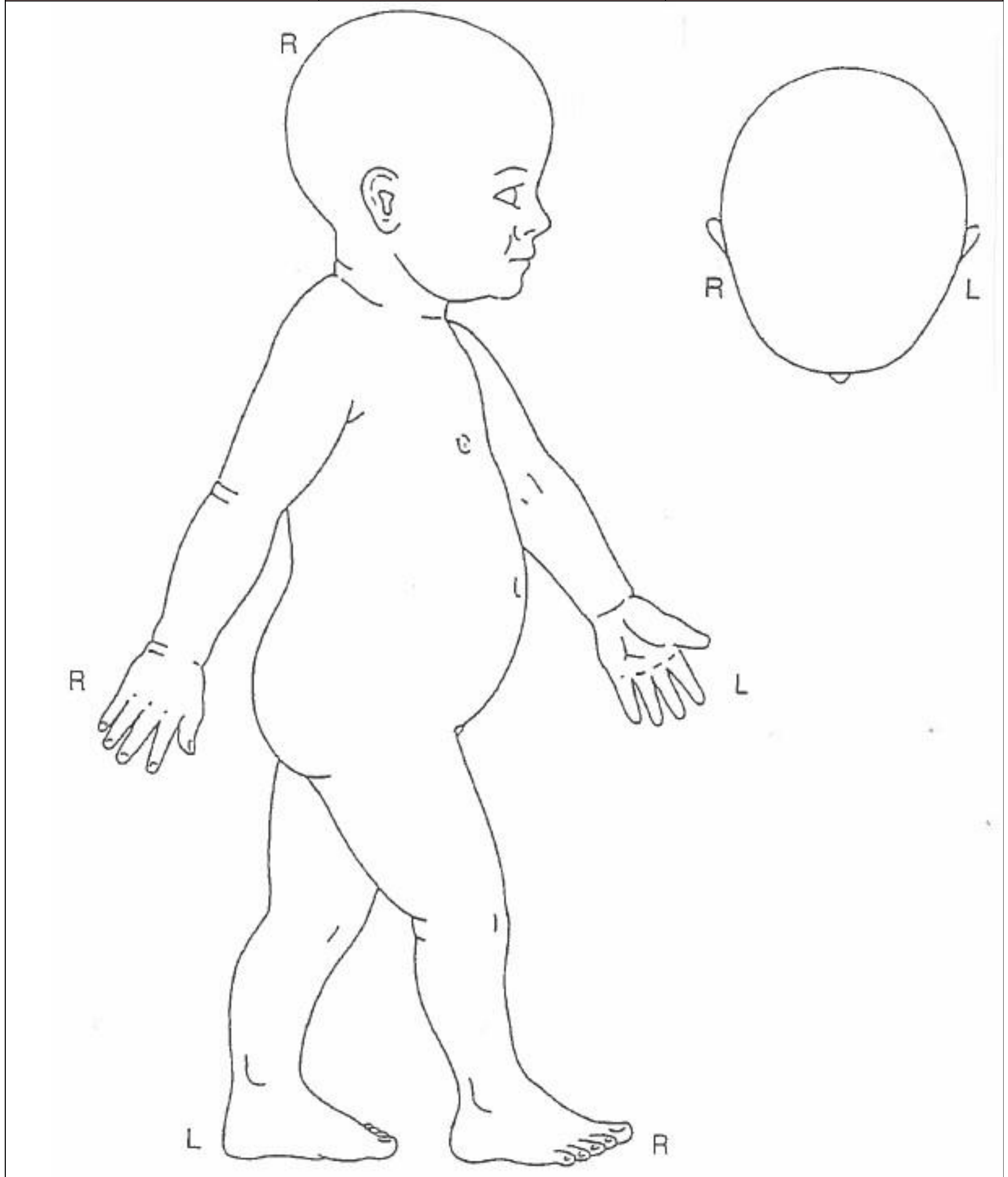
10. Contact details for Dorset and BCP Children's Social Care

Please refer to the Worried about a child - Dorset Council for contact details for Dorset Children's Social Care.

Please refer to the Concerns about child abuse or wellbeing | BCP (bcpcouncil.gov.uk) for contact details for BCP Children's Social Care.

APPENDIX 1: BODY MAPS

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



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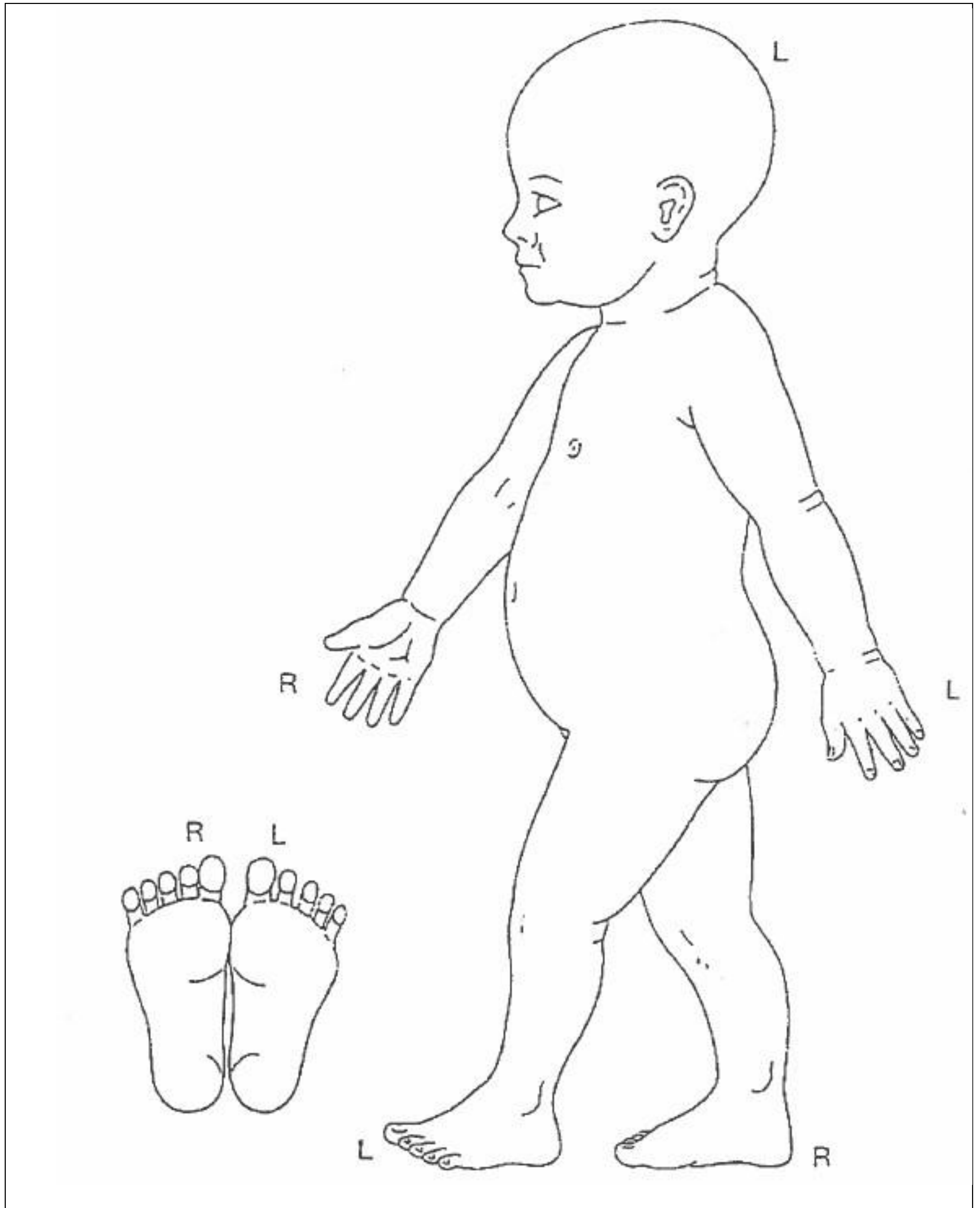

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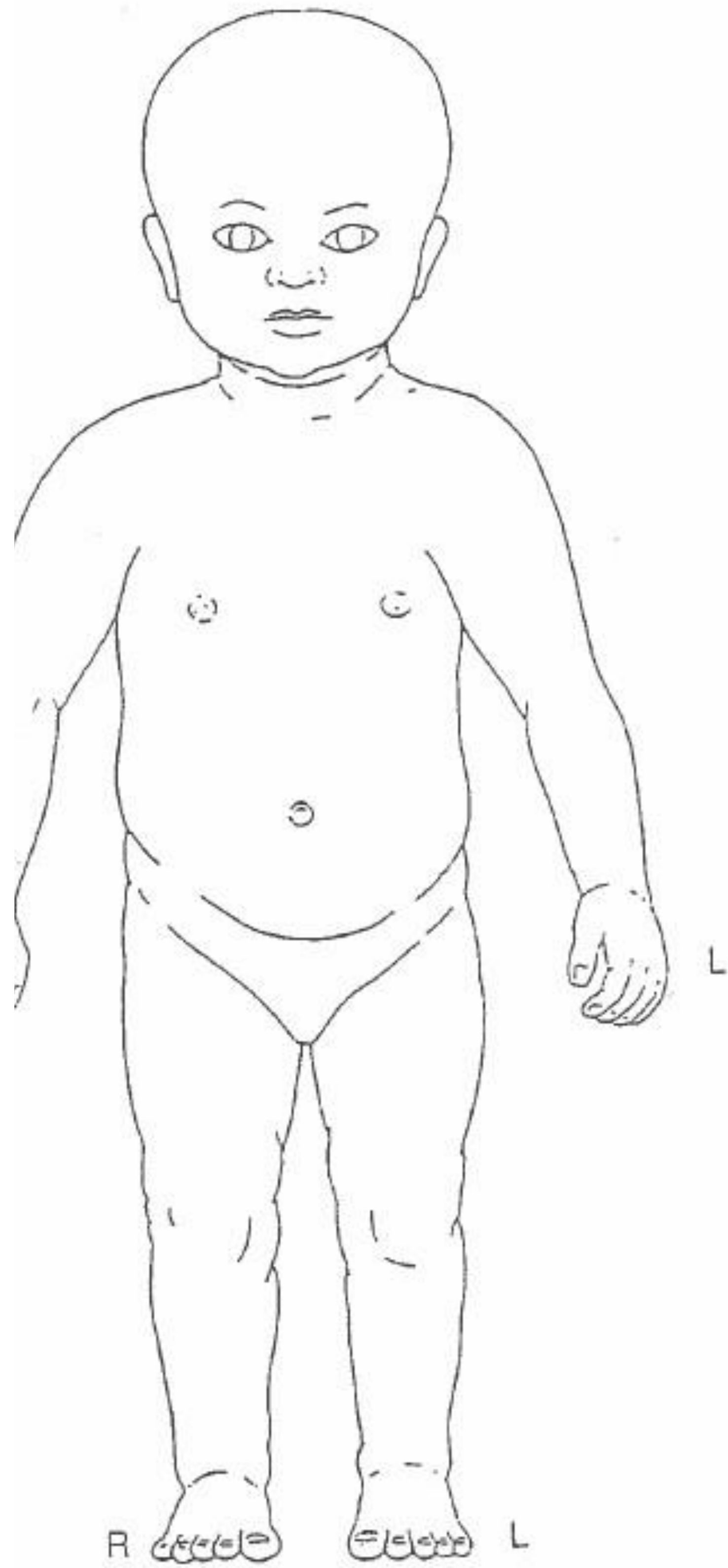

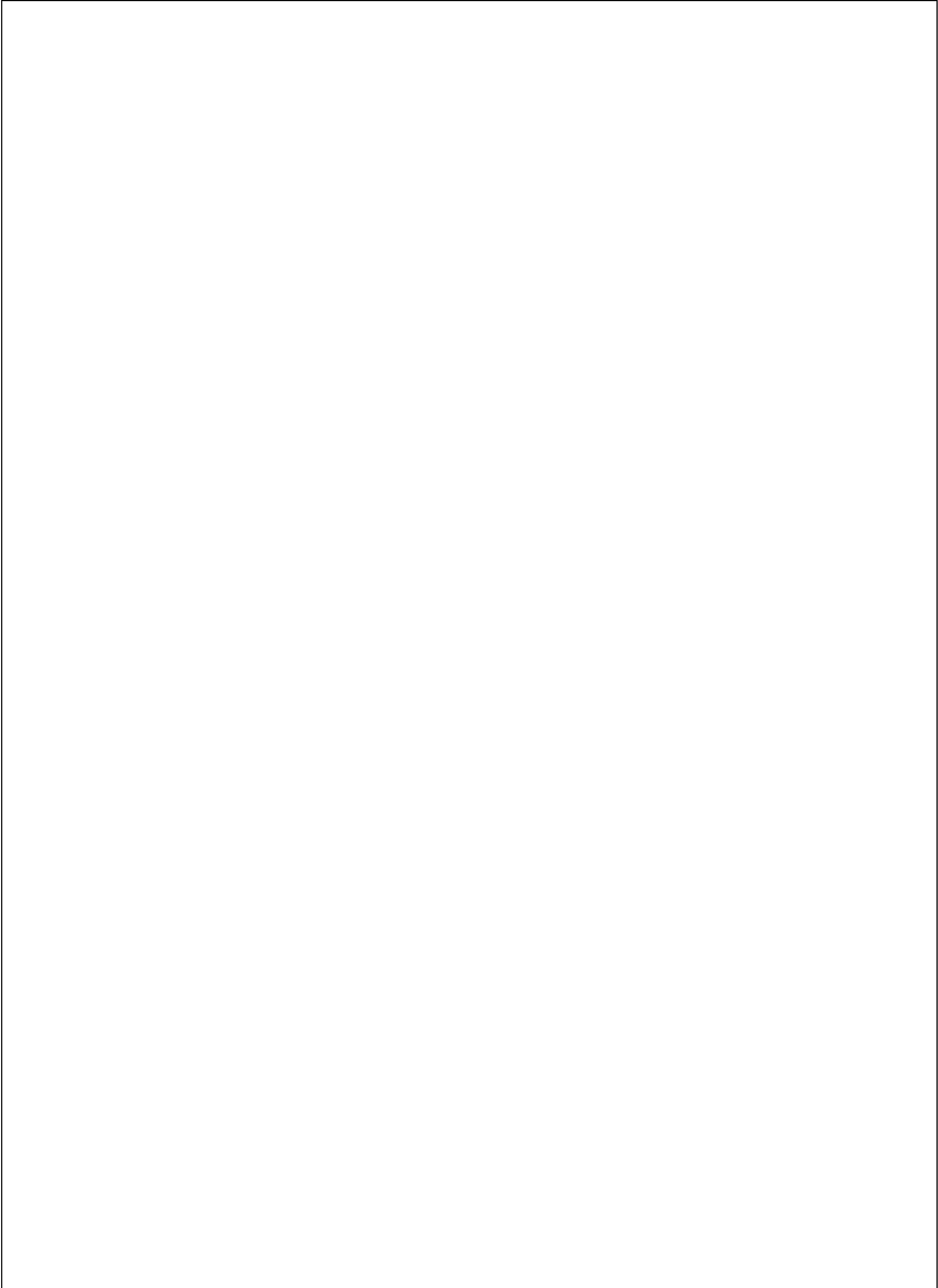

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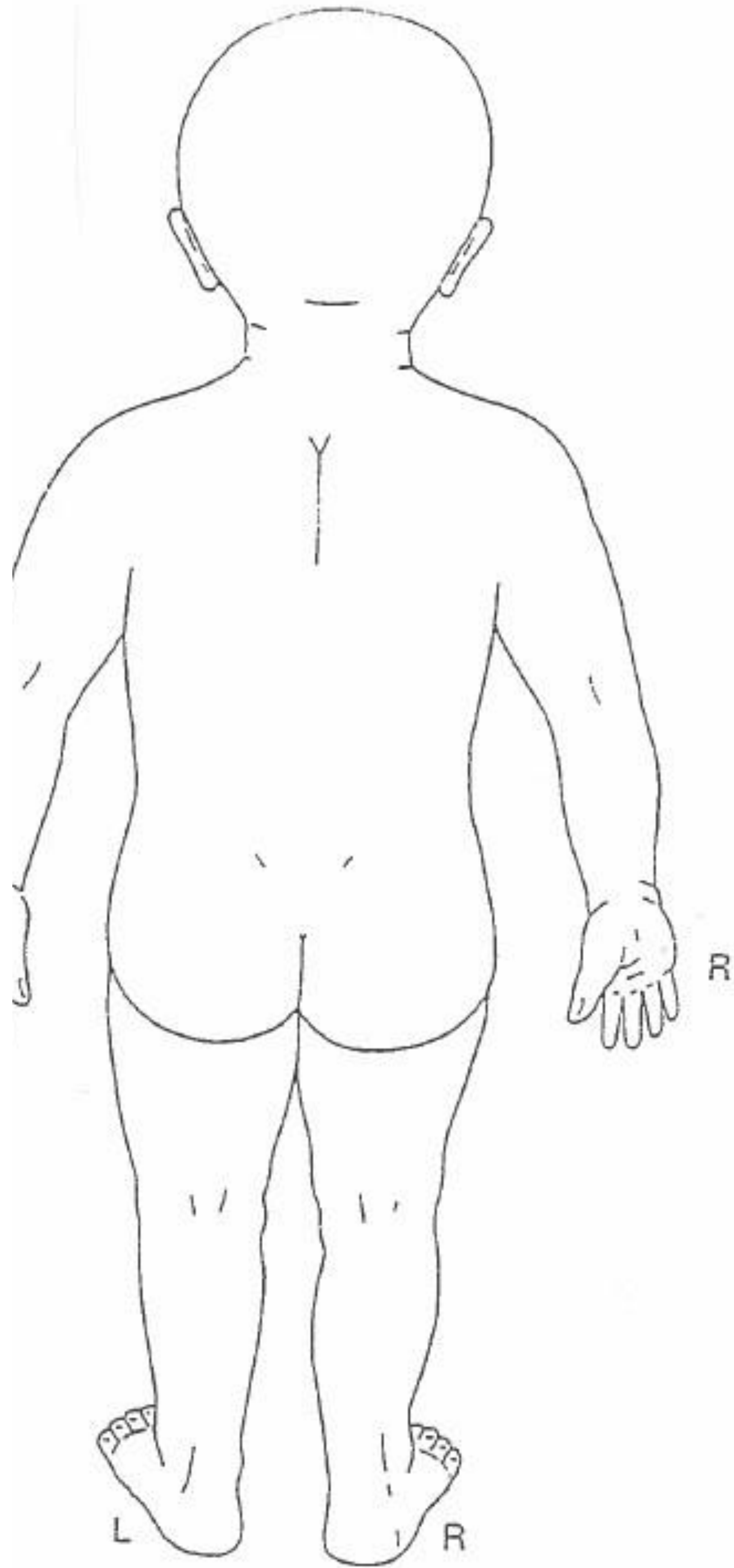

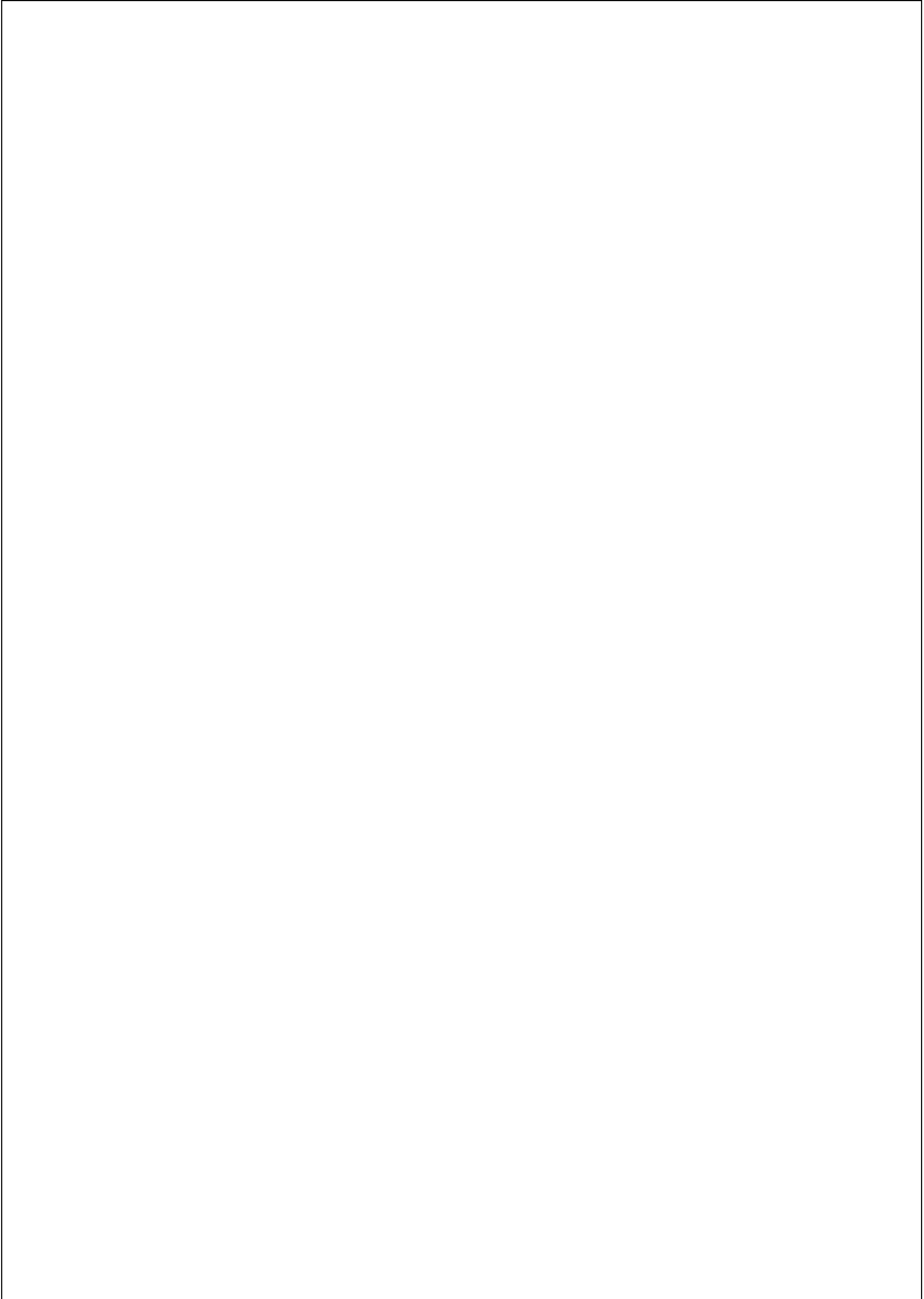

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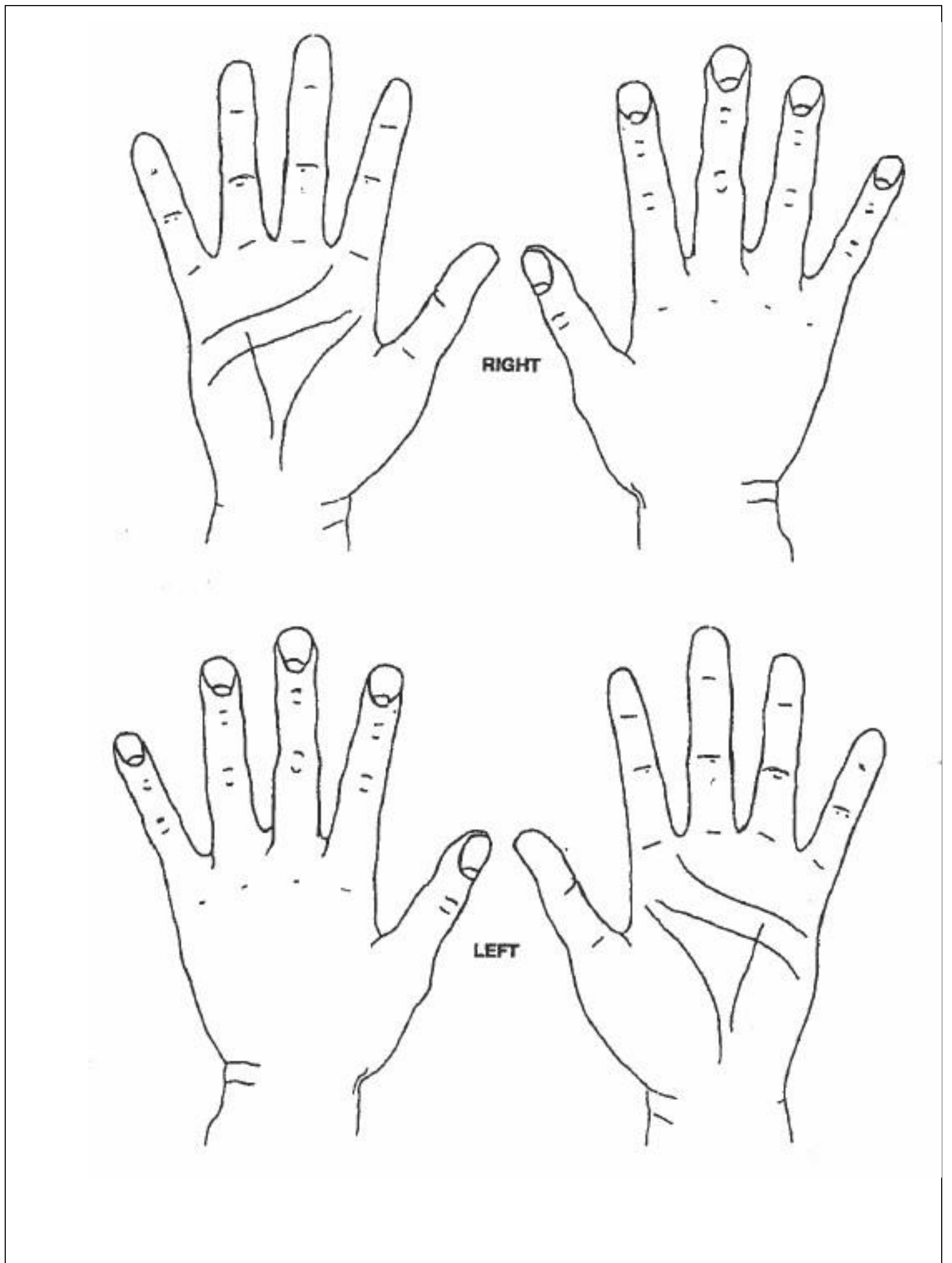
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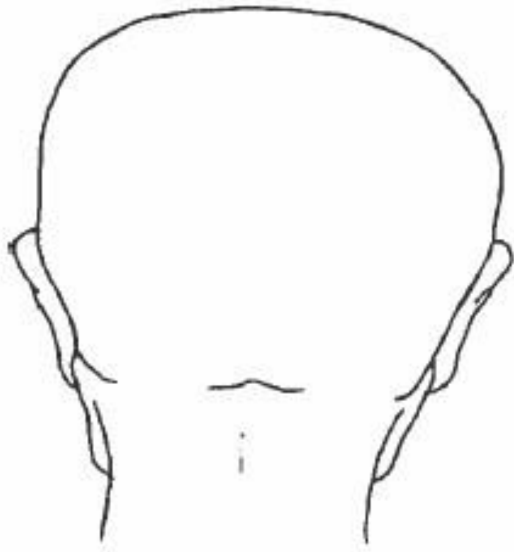
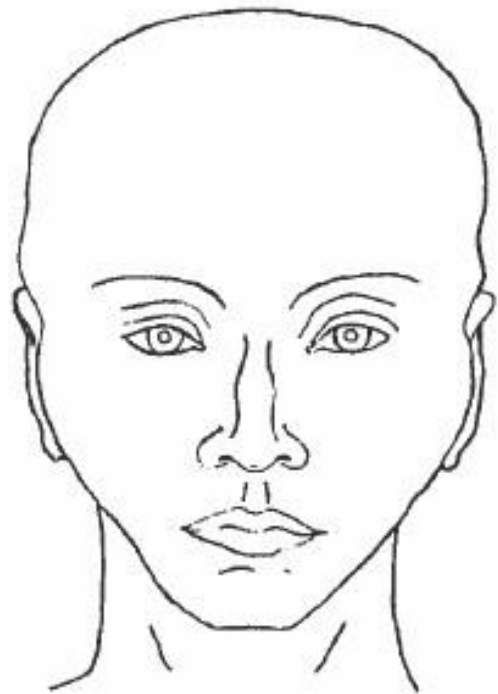
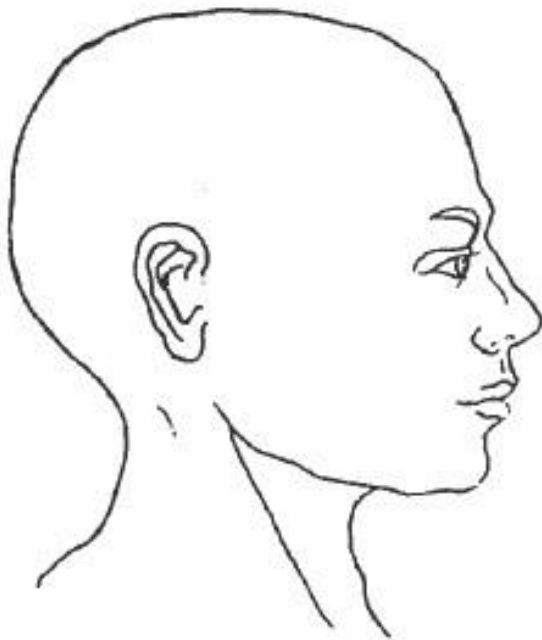
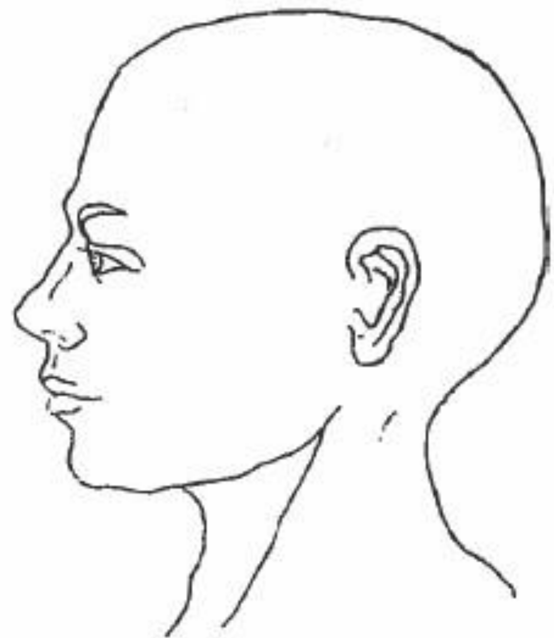

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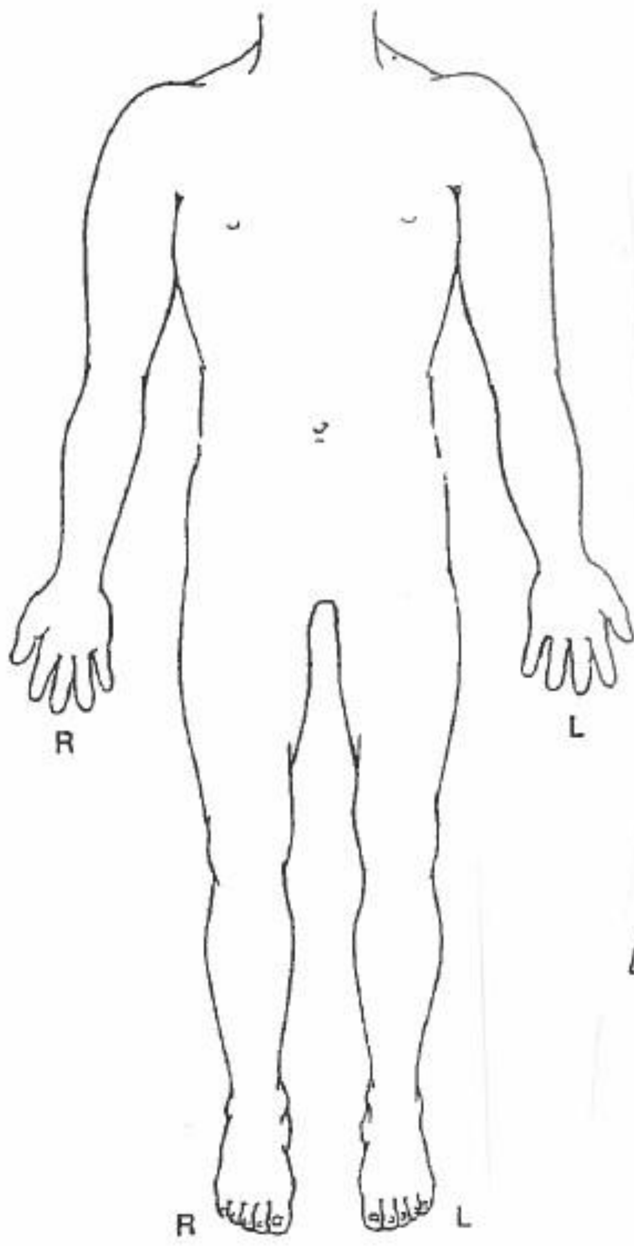

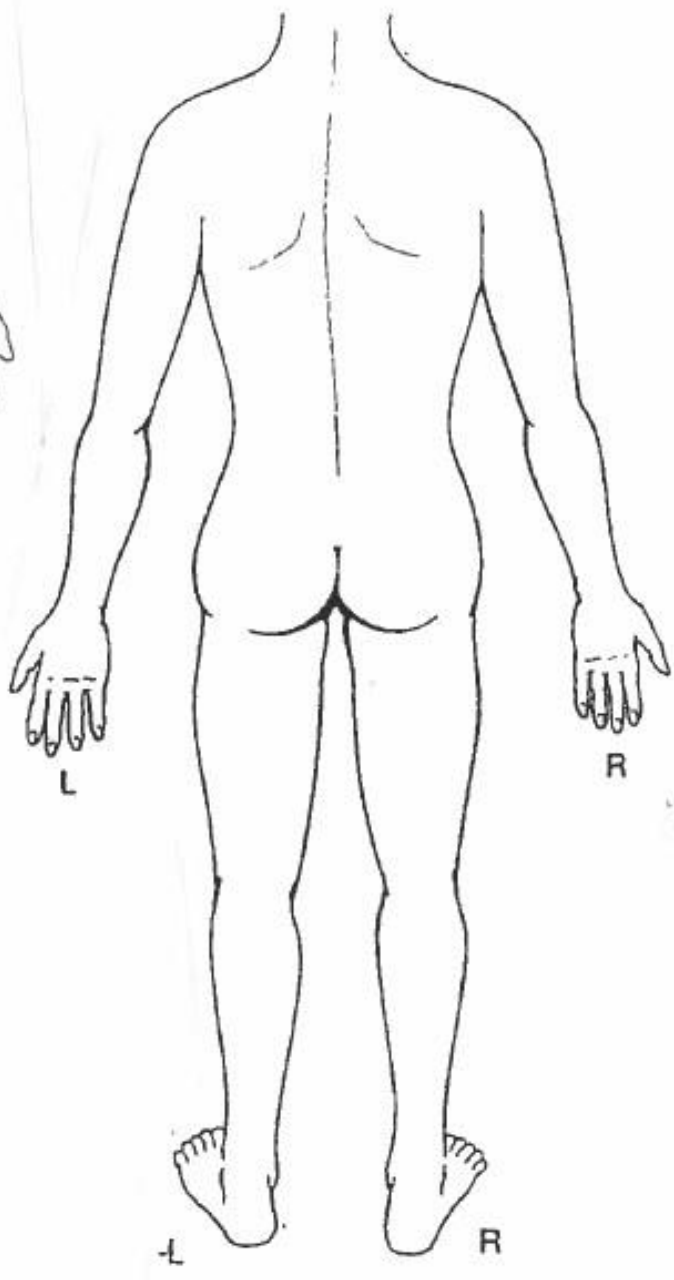

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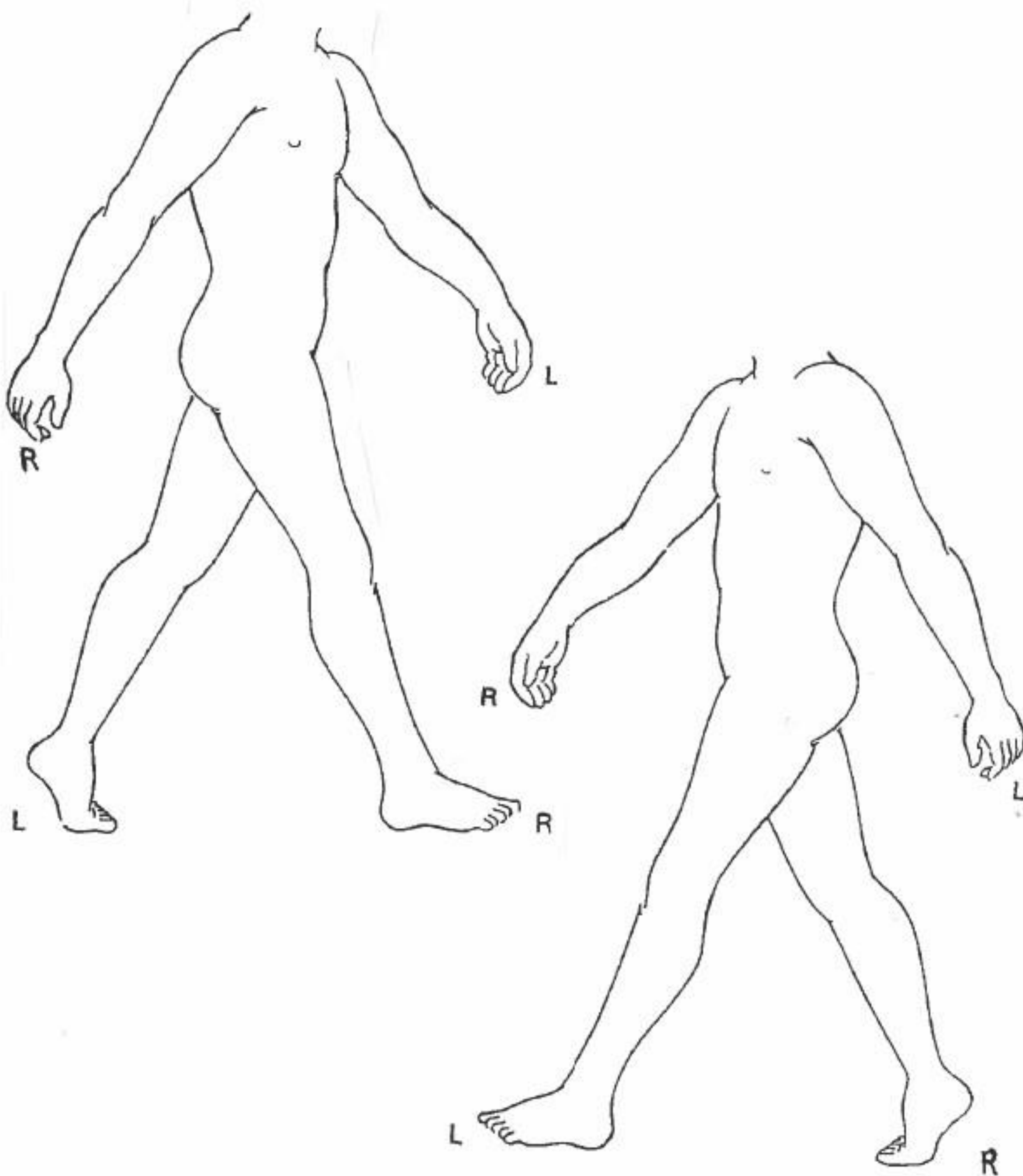

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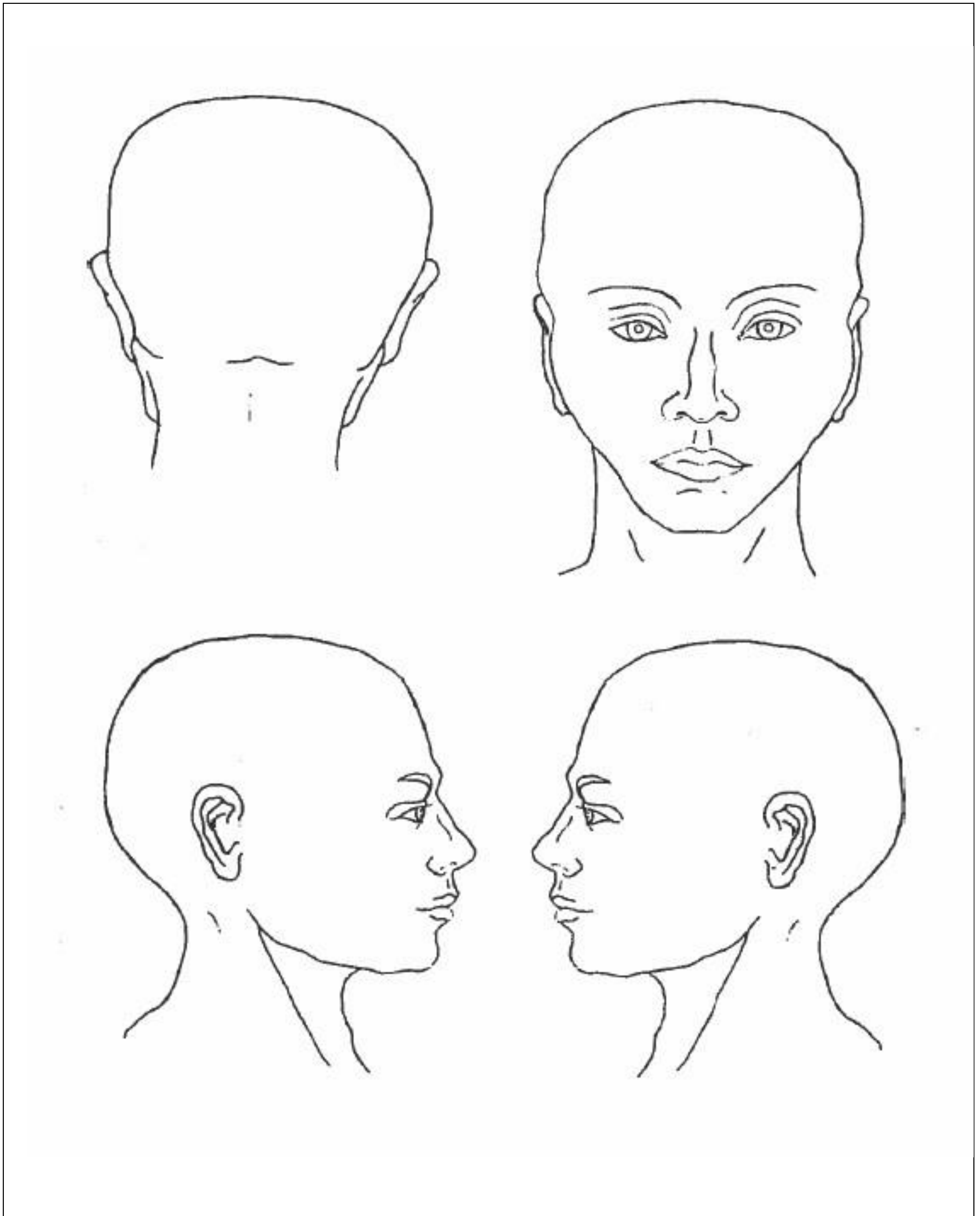

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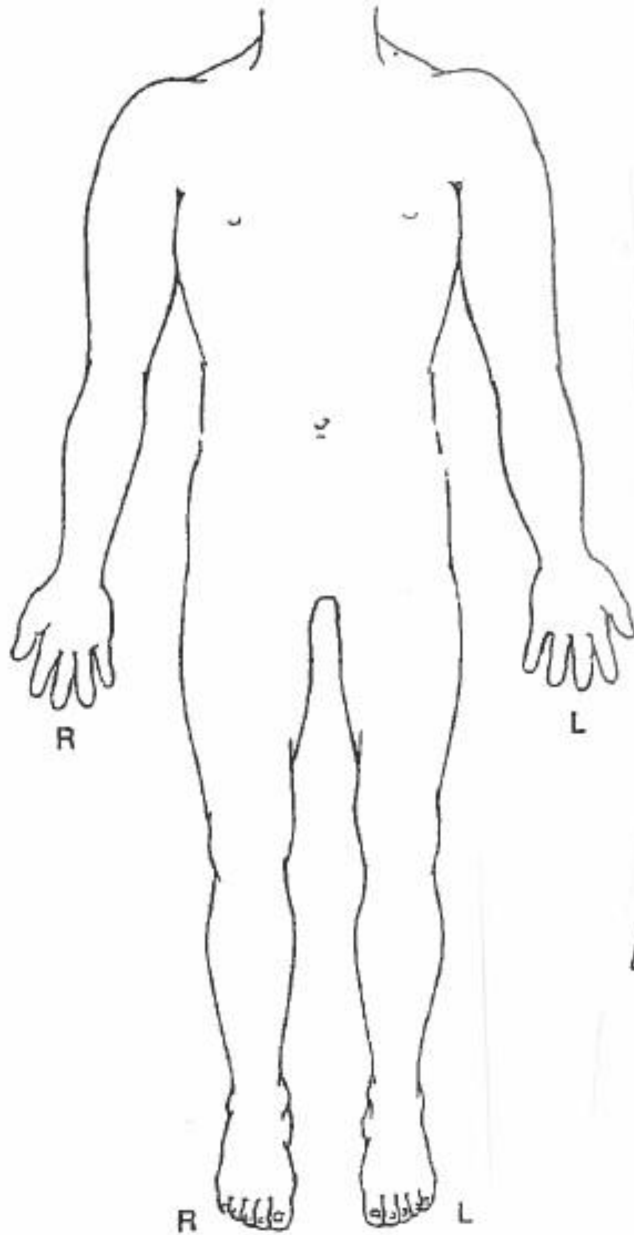

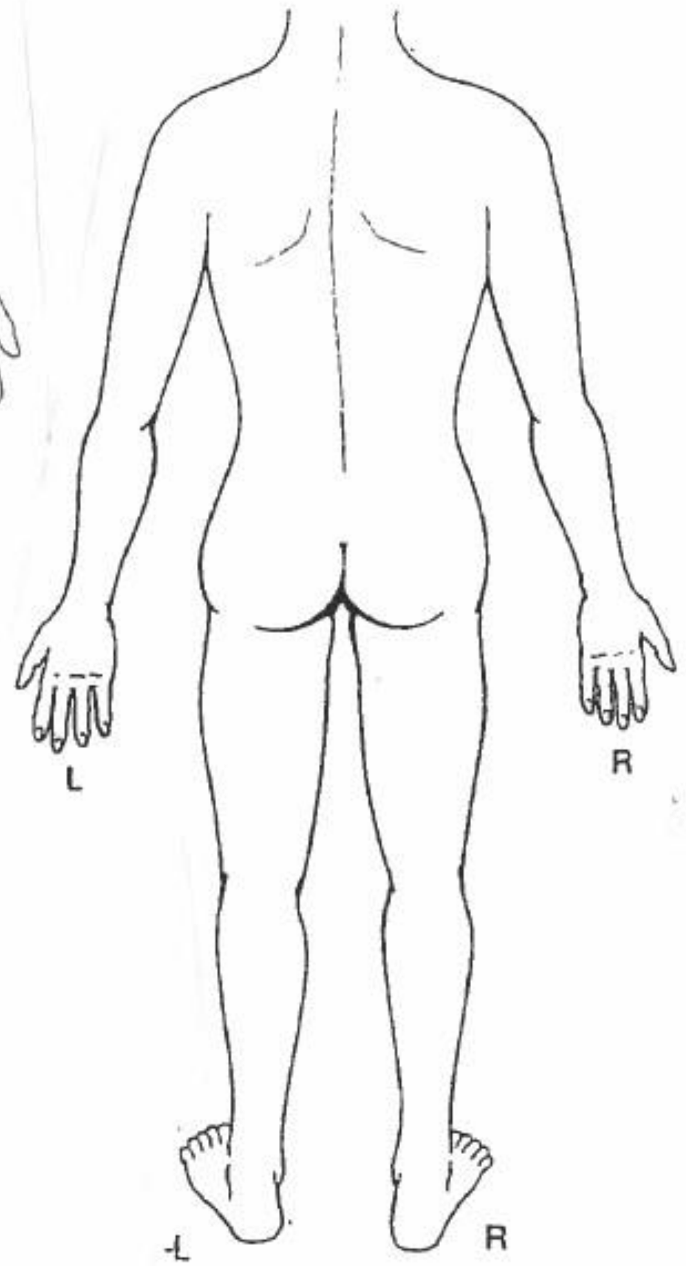

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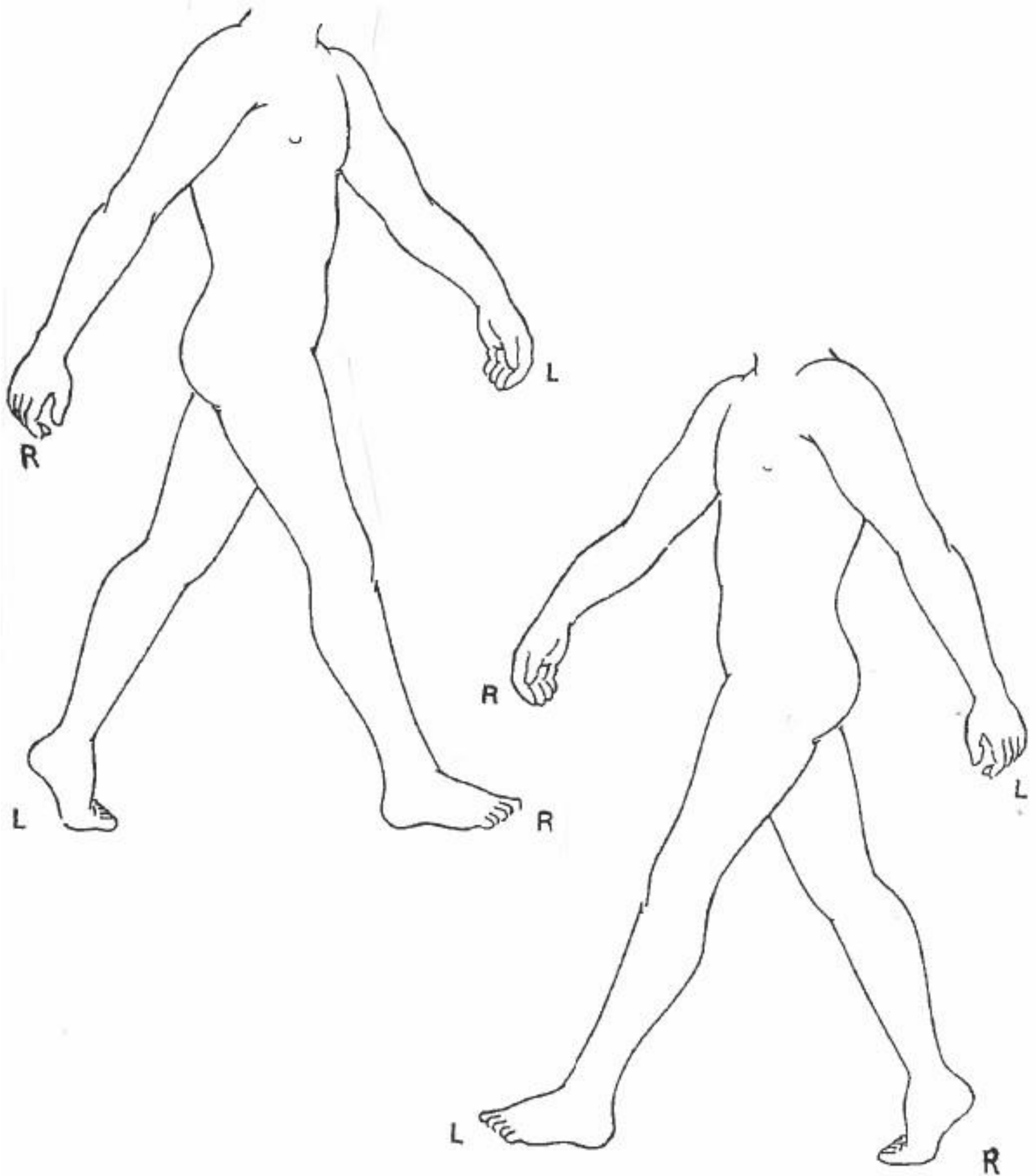

Appendix 2 - Categories of injuries to aid decision making about investigations and next steps.

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.