

Bruising in non-mobile

babies

|  |
| --- |
| Document control |
| Status | Guidance |
| Effective from | October 2020 |
| Who Must Comply with this Guidance? | BCP Childrens Practitioners |
| Who must be aware of this guidance?  | BCP Childrens Practitioners |
| Review Frequency | Annual |
| Policy Lead and Approval Body  | Quality Assurance |
| Produced By  | TN |

Table of Contents

[**1.** **Introduction** 3](#_Toc54169727)

[1.1 Bruising 3](#_Toc54169728)

[1.2 Unacceptable Explanation 3](#_Toc54169729)

[1.3 Identifications of Birth Marks/Birth Trauma 3](#_Toc54169730)

[**2.** **Definition** 4](#_Toc54169731)

[2.1 Non-mobile or Not Independently Mobile 4](#_Toc54169732)

[2.2 Bruising 4](#_Toc54169733)

[2.3 Physical Injuries 4](#_Toc54169734)

[**3.** **Process** 5](#_Toc54169735)

[**4.** **Action to Safeguard the Child** 6](#_Toc54169736)

[**5.** **Involving Parents or Carers** 6](#_Toc54169737)

[**6.** **The Medical Examination** 7](#_Toc54169738)

[6.1 Accidental Cause 7](#_Toc54169739)

[6.2 Possible Non-Accidental Cause 7](#_Toc54169740)

[**RELATED GUIDANCE** 8](#_Toc54169741)

# **Introduction**

# 1.1 Bruising

Bruising is the most common injury in physical child abuse and a common injury in non-abused children, the exception to this being in non-mobile infants where accidental bruising is rare (<1%). Diagnostic dilemmas centre around distinguishing abusive from non-abusive bruises and determining the age of the bruise (see [**Child Protection Evidence: Systematic Review on Bruising (RCPCH - 2020)**](https://www.rcpch.ac.uk/sites/default/files/2020-03/child_protection_evidence-_chapter_bruising_update_final.pdf)).

Any bruising, or mark on the skin that might look like bruising, in a child of any age or where a child is not independently mobile, that is observed by or brought to the attention of any professional must be taken as a matter for inquiry and concern.

Child maltreatment should be considered where bruises in children are unexplained, without an acceptable explanation, have a concerning presentation or involve a child that is not independently mobile. These concerns must result in an immediate Referral to the MASH.

# 1.2 Unacceptable Explanation

For the purposes of this guidance, an unacceptable explanation is one that is implausible, inadequate or inconsistent with the child or young person’s:

* Presentation;
* Normal activities;
* Existing medical condition;
* Age or developmental stage;
* Presentation and account given by parent/carer.

An explanation based on cultural practice is also unacceptable because this should not justify hurting or maltreating a child or young person (see: [**CG89: Child maltreatment: when to suspect child maltreatment in under 18s**](https://www.nice.org.uk/guidance/CG89)).

# 1.3 Identifications of Birth Marks/Birth Trauma

On occasions it can be difficult to know if a skin mark is suspicious or not - e.g. birth mark: Mongolian blue spot, haemangioma or marks that may be associated with recent birth trauma/delivery.

If the presenting concern is observed by a Health Practitioner, health records should be reviewed to confirm if there is any known notification of the skin mark (i.e. clear documentation of a birth mark).

Where there is no known recorded explanation and therefore diagnostic doubt regarding the nature of a skin mark and consideration to wider vulnerability factors have been excluded (see: **BCP Multi-agency Threshold descriptors)** an immediate discussion should take place between the Health practitioner and on call Paediatrician.

A decision should then be made to obtain a same day paediatric review to confirm observation of a birth mark/birth trauma.

Where the observing Health practitioner:

* has the clinical expertise underpinned by additional training to recognise/identified birth marks in babies/young children (which is recognised by the Safeguarding Partnership);

***and***
* is confident that the skin mark is due to a prior unidentified birth mark

they should reassure the parent/carer and ensure that this is clearly recorded (using a body map) in the baby’s/child’s health record. **Where there is any doubt regarding the presentation NOT being a birth mark, an immediate referral to MASH should be made**.

If the observing professional is not from health and therefore cannot confirm that the presenting skin mark is a birth mark, they should contact MASH for further advice.

# **Definition**

# 2.1 Non-mobile or Not Independently Mobile

A child is considered non-mobile if they are not yet crawling, bottom shuffling, pulling to stand, cruising around furniture or walking independently; includes all children under the age of six months. An older infant or child with a disability with any of the risk indicators would also warrant careful consideration.

**Non-Mobile:**a baby (or older child with a disability) who cannot crawl, pull to stand, ‘cruise’ around furniture, or is toddling. Babies or children who can roll are classed as **non-mobile** for the purposes of this procedure. Professionals must use their judgement regarding babies who can sit independently but cannot crawl, depending on severity of the injury, the account of the parent or care giver and the plausibility.

# 2.2 Bruising

Blood in the soft tissues; producing a temporary, non-blanching discolouration of skin however faint or small with or without other skin abrasions or marks. Colouring may vary from yellow, through green, to brown, or purple.

# 2.3 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, unless accompanied by a full consistent explanation. Even small injuries may be significant, and they may be a sign that another hidden injury is already present. Such injuries include:

* 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.

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.

# **Process**

Any explanation for the injury should be critically considered within the context of:

* The nature and site of the injury on the child;
* The baby’s developmental stage and abilities;
* The family and social circumstances including current safety of siblings/other children.

All people who live within the family home, including siblings and partners/significant others (such as aunts and uncles, grandparents, etc.) who do not live there but participate in any aspect of the child’s care, must be considered as part of the assessment.

Situations that should cause particular concern for professionals include:

* Delayed presentation / reporting of an injury;
* Admission of physical punishment from parents / carers - no physical punishment is acceptable;
* Inconsistent or absent explanation from parents / carers;
* Associated family factors such as substance misuse, mental health problems, and domestic abuse.
* Other associated features of concern e.g. signs of neglect such as poor clothing, hygiene and / or nutrition.
* Difficulty in feeding / excessive crying;
* Significant behaviour change;
* Infant displays wariness or watchfulness;
* Recurrent injuries;
* Multiple injuries at one time.

# **Action to Safeguard the Child**

Bruising in immobile babies is rare and must always result in an immediate contact and referral to MASH.

Bruising in any child with no acceptable explanation or that has a concerning presentation must also result in an immediate contact and referral with MASH.

Where the baby/child is an open case to Social Care, agencies, in addition to contacting the MASH, should always contact the allocated Social Worker to make them aware of events and discuss any actions taken or required.

It is the responsibility of any partner agency practitioner who learns of or observes concerning bruising on a non-mobile/mobile child to make the referral. Where appropriate the referring practitioner may want to discuss the concerns to refer with another professional or [**Named Professional**](http://trixresources.proceduresonline.com/nat_key/keywords/named_professional.html) or Designated Safeguarding Lead. **However, this discussion should not delay a practitioner referring to Children's Services, any child with bruising who in their judgement may be at risk of significant harm.**

If a referral is not made, the reason why a referral has not been undertaken must be documented in detail in the child’s records with the names of the practitioners taking this decision. All telephone referrals to MASH must be followed up in writing.

It is the responsibility of Children's Social Care Services in conjunction with the local acute or community paediatric department to decide whether the circumstances of the case and the explanation for the injury/presenting concern are consistent with an innocent cause or potential maltreatment. Children should NOT be referred to GPs for a decision as to whether any ‘bruising/injury’ is accidental or otherwise. A [**Strategy Meeting**](http://trixresources.proceduresonline.com/nat_key/keywords/strategy_meeting.html) should be held to determine whether the child is at risk of [**Significant Harm**](http://trixresources.proceduresonline.com/nat_key/keywords/significant_harm.html). Decision making regarding the required Child Protection investigations will be agreed at the Strategy Meeting/Strategy Discussion. The risks for any siblings or significant children living in the same household should also be considered and Safeguarding processes afforded accordingly.

A bruise/injury must always be assessed in the context of medical and social history, developmental stage and explanation given. Assessments will be led by Children's Social Care and a lead medical professional (local acute or community Paediatrician) to determine whether bruising is consistent with the explanation provided or is indicative of non-accidental injury. Children's Social Care will co-ordinate multi-professional information sharing and assessment.

# **Involving Parents or Carers**

As far as possible, parents or carers should be included in the decision-making process, unless to do so would jeopardise information gathering (e.g. information or evidence could be destroyed) or if it would pose a further risk to the child.

In particular practitioners should explain at an early stage why, additional concern, questioning and examination are required.

If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children's Social Care Services. If possible, the child should be kept under supervision until steps can be taken to secure his or her safety.

Where admission to hospital is required, the necessity to supervise the parent/carer’s contact with the child in order to protect from further risk should considered. This supervision will be coordinated by children’s social care and should be clearly documented in Health records for clarity.

# **The Medical Examination**

A Paediatrician should take into account the developmental capabilities of the baby and all information provided when the cause of the injury is being assessed. Risk to siblings and other children in the household should also be considered.

# 6.1 Accidental Cause

If the cause of the injury is assessed as accidental, the Paediatrician should still ensure that families of non-mobile babies are referred to MASH. Multi-agency Threshold descriptors should also be considered for any wider vulnerability factors that may warrant/support referral to social care.

If the additional information suggests that the baby has been abused or neglected, or is at risk of significant harm, a referral to MASH should be made.

If after consultation with MASH it is judged that the injury is accidental but the baby already has an allocated Social Worker, the Paediatrician must ensure that the social worker is informed verbally and in writing of the outcome of the medical examination.

# 6.2 Possible Non-Accidental Cause

The Paediatrician must take steps to immediately safeguard the baby if the injuries are assessed as non-accidental.

Where the baby is unknown to Social Care a referral should be made immediately, discuss with the MASH Social Worker the outcome of the medical examination and any follow up action required. Both should be clear about what actions are to be taken and who is responsible for implementing these actions. Consider supervision of parent/carer on ward. A Strategy Meeting should be held as soon as possible.

If there is any disagreement between professionals regarding the safety of a child it must be resolved using the follow the escalation procedure as outlined in the LSCB.

# **RELATED GUIDANCE**

* [**Bruises on Children (NSPCC)**](https://www.nspcc.org.uk/globalassets/documents/advice-and-info/core-info-bruises-children.pdf)
* [**Child Protection Evidence: Systematic Review on Bruising (RCPCH - 2020)**](https://www.rcpch.ac.uk/sites/default/files/2020-03/child_protection_evidence-_chapter_bruising_update_final.pdf)