Multi-agency Bruising Protocol for Children Not Independently Mobile (for Front-line Practitioners)

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JFDI Level	Level 3 – CSWS, Education and Early Start, West Yorkshire Police and Health Agencies (Clinical Commissioning groups (CCGs), Leeds Community Healthcare (LCH), Leeds Teaching Hospitals Trust (LTHT) and Leeds and York Partnership Foundation Trust (LYPFT)) Level 1 – all other Partner Agencies and Clusters

Introduction

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 children who are not independently mobile. The definition of not independently mobile includes children not yet crawling, cruising or walking independently. 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. The majority of children who are not independently mobile are babies, but it is important to also consider older children with a physical disability whom are also not independently mobile

Indeed the National Institute of Clinical Excellence guidance (NICE) Clinical Guideline 89 (updated August 2012) states that bruising in any child not independently mobile, should prompt suspicion of maltreatment.

See: http://www.nice.org.uk/guidance/CG89

Bruising is the most common accidental injury experienced by children and research shows that the likelihood of a baby sustaining accidental bruising increases with increased mobility. **It is extremely rare for a non-mobile baby to sustain accidental bruising**. Therefore, all such bruising 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**.

Aim

The aim of this protocol is to provide frontline staff with a knowledge base and action strategy for the assessment, management and referral of children who are Not Independently Mobile who present with bruising or otherwise suspicious marks.

This protocol sets out when children should be referred for further assessment and investigation of potential child abuse. The protocol also outlines the process for hospital staff.

In the light of the NICE guidelines “When to Suspect Child Maltreatment” (2009), 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. It requires that staff should not be making decisions about the mechanism of the injury independently. However, information gathered in the investigation period should be shared with a GP and/or Paediatrician.

Definitions and Terminology

Front-line practitioners: in line with "Working Together to Safeguard Children" (2013) this includes: teachers, GPs, nurses, midwives, health visitors, school nurses, early years professionals, youth workers, police, accident and emergency staff, paediatricians, voluntary and community workers and social workers. Working Together 2006 introduced the concept that "safeguarding is everybody's responsibility" and the 2013 update states that "Everyone who works with children or with adults who have children in the family has a responsibility to keep them safe and to share information in a timely way." This should be actioned regardless of the seniority of the practitioner. When considering children with physical disabilities, front line practitioners include staff in specialist educational provision and Children's nurses.

Not Independently Mobile: 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, although this is rare. In addition, some medical conditions can cause marks to the skin in very young babies that may resemble a bruise. In all cases, unless the specific mark that has been identified is already confirmed as arising from a medical condition, this protocol should be followed to enable multi-agency assessment of the suspected bruise. An example of medical bruising is Mongolian blue spot, 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

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 not 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 and social history, developmental stage, explanation given and this should be shared with an appropriately qualified medical practitioner. 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 a satisfactory explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history, to ensure that it is consistent with an innocent explanation.

Follow up of the Child (Community)

This protocol requires **any front-line practitioner** who identifies a bruise to a baby, who is not independently mobile, to make an assessment of:

- what happened, how it happened, when it happened
- if there were any witnesses and the extent of the injury
- the significant possibility that the bruising may have arisen as a result of abuse or neglect

If the practitioner is concerned (e.g. the narrative provided is implausible, or there are any other safeguarding concerns), then a referral to CSWS will be required. Where a decision to

refer is made, it is the responsibility of the first professional to learn of or observe the bruising to make the referral.

Wherever possible, the decision to refer, should be undertaken jointly with another professional or senior colleague. However, this requirement should not prevent an individual professional of any status referring to CSWS any child with bruising who in their judgement may be at risk of child abuse.

Prior to making the referral, the professional should ensure that they have sufficient information to assist CSWS in responding. This would include basic details such as name, date of birth, address etc. as well as details of parents/carers and any other relevant background information that is known at the time. The parent, where it is safe to do so, must be aware of the referral although consent is not required.

If the family are already known to CSWS then the front-line practitioner should inform the SW as soon as is possible. In the event that there are no safeguarding concerns and the narrative is plausible, the **child should still be seen** by an appropriate qualified and registered medical practitioner (e.g. General Practitioner). In this instance it is the frontline practitioner's responsibility to inform the GP of why the attendance is being requested and to follow up and ensure that the child has been assessed. If concerned, the GP should refer to CSWS. If not concerned, then the front-line practitioner should then liaise with other practitioners working with the family and ensure their documentation is up to date.

Follow up of child (Hospital)

When concerns have been identified for children within accident and emergency department, such children should be referred directly to the Paediatric Medical Team, who will comprehensively assess the child, incorporating consultant paediatrician and social care opinion.

Paediatric Opinion

When a child is referred to CSWS (by a community practitioner) 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).

For further guidance on requesting a child protection medical go to:
http://www.leedslscb.org.uk/LSCB/media/Images/pdfs/Pathway-Leeds-CP-medicals.pdf

Professionals should also consider the needs of other children in the family who may be affected. Where concerns are raised CSWS should convene a strategy discussion and consideration given to possible need for child protection medical examinations of other children in the family.

For further advice on conducting strategy discussions go to:
http://westyorkscb.proceduresonline.com/chapters/p_strat_disc_brad.html

For a paediatric opinion contact:

- During office hours (8.30am – 5.00pm)
  Tel: 0113 2064327

- At all other times:
  Call the on-call Paediatrician for the hospital Tel: 0113 2433144

The referral 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.**

The consultant community paediatrician must liaise with CSWS with regards to the outcome of the assessment as soon as it is completed. It is expected that all referrals (and notification of the existing Social Worker) under this protocol, will be responded to and assessment commence, on the same day that the referral is received.

Where a referral 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.