BRUISING AND SUSPECTED NON-ACCIDENTAL INJURIES (NAI) IN PRE-MOBILE INFANTS and NON-MOBILE CHILDREN

A Protocol for Wandsworth Safeguarding Children Partnership (WSCP) Multi-Agency Professionals working with babies and children in Wandsworth

Original Bruising Protocol kindly shared by Barnet SCP and adapted for Wandsworth by Dr Claire Taylor Named GP (credit to original authors Paul De Keyser et al) May 2023

1 THE KEY MESSSAGES

1.1 Bruising is the most common presenting feature in physical abuse in children.

1.2 Accidental bruising in pre-mobile infants is rare.

1.3 The younger the child is, the higher the risk that the bruising is non-accidental, especially where the child is under 6 months. Bruising or injury in any child 'not independently mobile' should prompt suspicion of Non Accidental Injury (NAI)

1.4 Bruising or injury in any pre-mobile infant should prompt an immediate discussion with a Safeguarding professional for the organisation in which the professional works, and if considered appropriate, a referral made to Children's Social Care.

1.5 Circumstances that may not require additional safeguarding enquiries include where:

- the professional is aware that the bruise or injury has been previously documented and noted as being due to a medical condition or birthmark
- an accidental bruise or injury has been witnessed by a professional
- a plausible explanation from a parent or carer and child, and there is no concern regarding the explanation for the bruise or injury or the circumstances of the presentation.

For all the above to apply this must be in the absence of any other previous safeguarding concerns regarding the infant or family.

1.6 The requirement to consult with their Safeguarding professional should not prevent an individual professional referring to Children's Social Care any child with bruising or a suspected NAI who in their judgement may be at risk of child abuse.

Any child found to have suspicious bruises or marks, is seriously ill or injured, or is in need of urgent treatment or investigation, must be immediately referred to hospital without delay. Professionals must understand that the younger and smaller the greater the risk of internal injury.

Referral to hospital should not be delayed by a referral to Children's Social Care: this can be made from the hospital setting. It remains the responsibility of the professional dealing with the case to complete this and to phone ahead to the hospital to share NAI concerns.

1.7 When making an assessment and referral a professional should always review the information held within their agency with regards to the family and child to identify any relevant and associated risk factors that will need to be shared with social care. This includes parental and/or child risk factors.

1.8 Children's Social Care should take any referral made under this protocol as requiring consideration for further multi agency investigation and should check local systems for any risk factors and consider whether a Strategy Meeting is required to include the consideration of a Child Protection Medical Examination being undertaken by an appropriate Paediatrician.

1.9 The decision regarding whether a Child Protection Medical Examination (CPME) is undertaken should be made within a Strategy Meeting at which there needs to be representation from Social Care, Police and Health agencies.

A decision not to carry out a CPME must be clearly documented with rationale. The referrer and social worker should consider the medical needs of the child and whether medical assessment is still required.

1.10 The timing of a CPME should be determined by the circumstances of the case and may benefit from an early discussion between paediatrician, social worker, and Police. If a child needs urgent medical assessment or treatment she must be taken to the nearest emergency department. The procedures to gather and preserve evidence may be carried out at the same time e.g., photographs of injuries.

2 WHAT IS THE AIM OF THE PROTOCOL?

2.1 The aim of this protocol is to provide frontline health, police, social care, education and third sector organisation professionals with a knowledge base and action strategy for the assessment, management and referral of pre- mobile infants and non- mobile children and young people who present with bruising or unexplained injury.

3 WHO IS THIS PROTOCOL FOR?

3.1 All professionals working with pre-mobile infants and non-mobile children or young people.

4 DEFINITIONS USED IN PROTOCOL

4.1 Pre-mobile infant: An infant who is not yet crawling, pulling to stand, bottom shuffling, cruising, or walking independently. For the purposes of this protocol, this includes all infants under the age of six months, in addition to those infants 6 months or over who have not yet achieved their first of the above milestones.

4.2 Non-mobile child or young person: A child or young person who for reasons of disability or developmental delay is unable to move independently through crawling, cruising, or bottom shuffling. Particular attention should be given to the risks in those children who are unable to roll over independently.

4.3 Bruising: A bruise is a haematoma that forms due to bleeding under intact skin into subcutaneous tissue, caused by vascular damage or injury. The colour of a bruise is not a reliable indicator of the age of a bruise, and there is a wide variability in the appearance and healing of bruises, both among individuals and among bruises on the same person. (NICE Clinical Knowledge Summary – Bruising. March 2021)

NB: It is not possible to age bruises based on their colour.

4.4 A Non- Accidental Injury (NAI): Any abuse such as a bruise, mark, burn or other injury purposefully inflicted on a person or sustained because of a failure to protect the child from an injury, where that failure reaches a threshold of neglect.

5 INTRODUCTION AND BACKGROUND

5.1 Bruising is the most common injury in children who have been abused. It is also a common injury in non-abused children, the exception to this being pre-mobile infants where accidental bruising is rare. The number of bruises a child sustains through normal activity increases as they get older and their level of independent mobility increases (RCPCH Child Protection Evidence Systematic review on Bruising: March 2020)

5.2 NICE guidance when to suspect child maltreatment (Clinical Guideline 89, updated in October 2017) states that bruising in any child not independently mobile should prompt suspicion of maltreatment Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE

5.3 This protocol has been developed for the assessment and management of bruising and suspected NAI in pre-mobile infants and non- mobile children and young people, including multi agency participation within the assessment process of those children who are referred to Children's Social Care.

5.4 Identification of a skin mark as a bruise can be challenging. Practitioners should feel supported to act in line with this protocol should they believe there is a possibility the observed skin mark could be a bruise or NAI.

5.5 Skin marks can birth marks or areas of skin pigmentation such as the often blue/ grey marks known as 'Neonatal (Mongolian) blue spots' which commonly appear at birth or soon after, or may be the result of birth trauma. These marks should be recorded within the PCHR (Personal Child Health Record) and/or within the child electronic records. Should there be any doubt as to the nature of the mark on the child this protocol should be followed.

5.6 Some children may have disabilities that impact on their mobility, and practitioners should consider the extent of those disabilities, and whether a child is most appropriately assessed within the context of this protocol, or alternatively as a mobile child. If in any doubt, professionals should consult with their safeguarding lead or manager for further advice.

6 ASSESSMENT OF BRUISING AND INJURY IN PRE-MOBILE INFANTS AND NON-MOBILE CHILDREN AND YOUNG PEOPLE

6.1 In **ALL CASES** of observed bruise or injury, an explanation should be sought, and the explanation(s) recorded. It is imperative that the professional does not suggest to the parent/carer how the injury may have occurred.

6.2 Any explanation for the bruise or injury should be critically considered in the context of:

- The nature and site of the bruise or injury, whether the event was witnessed or unwitnessed, and who was present.
- The medical history and developmental abilities of the child.
- The family and social circumstances, including current safety of siblings

6.3 An infant body map (Appendix 1) or child body map (appendix 2) must be completed, detailing the site, size and presentation of the bruise or injury, and uploaded to or included in the child's records.

6.4 It is important that the assessment of the bruise or injury and decision making is fully recorded and documented, including exactly the account of how an injury occurred and who has given that account. Where possible professionals must speak directly to the child and record any non-verbal cues. It can be useful to make a drawing or ask the person recounting the events of the injury to make a drawing of how it happened, e.g.; where the child was lying on the bed when they fell.

6.5 The assessment of the family and social circumstances, including analysis and decision making must be documented. Particular attention should be paid to whether the reported mechanism is consistent with the injury, citing who was with the child or young person at the time and whether there are any concerns surrounding supervision of the child and the presentation of the parents.

6.6 Situations that should cause particular concern for professionals include:

- Delayed presentation / reporting of an injury without reasonable explanation.
- Significant injury where there is absent or inconsistent explanation from parent/carers
- Explanation that does not fit with the pattern of injury seen.
- Explanation that does not fit with the motor development of the child.
- Child gives a different account.
- Head Circumference shows significant increase on the centile chart.
- Admission of physical punishment from parents / carers
- History of an inappropriate response from the child, e.g.; the absence of pain or crying.
- Family factors e.g.; substance misuse, mental health problems and domestic abuse.
- Other signs e.g.; neglect; poor clothing, poor hygiene malnutrition
- Rough handling noted in the presence of professionals.
- Difficulty in feeding and excessive crying.
- Significant behavioural change.
- Infant displays wariness or watchfulness.
- Recurrent injuries.
- Multiple injuries at one time.
- Concerns expressed to professionals by family members.
- Concerns regarding parent-child interaction, attachment, or supervision of a child.

6.7 All those living within the family home as well as paid carers and co-parenting partners who may not live at the address, must be considered as part of the assessment.

6.8 If the alleged injury occurred at school or nursery a referral should be made to the Local authority designated officer (LADO). This should be discussed with the referrer's safeguarding manager.

7 RECOGNITION OF PHYSICAL ABUSE

7.1 Patterns of bruising that are suggestive of physical abuse include:

- Bruises that are seen away from bony prominences
- Bruises around soft tissue areas at sites that include the ear, neck, cheeks, buttocks, back, chest, abdomen, arms, hands, and posterior thigh. However, no site is specifically indicative of physical abuse.
- Multiple bruises in clusters including on the upper arm, chest, outside of the thigh, bruises on the chest, abdomen, and adjacent limbs.
- Bruises that carry an imprint, for example of a belt buckle, handprint, or grip mark.
- Bruises with petechiae (dots of blood under the skin) around them.
- Bruises that may be associated with sexual abuse include lower abdomen bruises, grip mark patterns around buttocks, tops of the thighs or genitalia.
- Petechial bruising from suction ("love bite"), particularly to the neck, thigh or breast/chest should also raise concerns if not in the context of age-appropriate consenting sexual activity.
- There are case reports of young babies causing suction bruises on places they can reach, such as their arms, in conjunction with a clear, appropriate, and witnessed history. Bruising and suspected non-accidental injuries (NAI) in pre-mobile infants and non-mobile children 8
- Studies of bruising patterns in children with disabilities showed that the dorsum of the feet, thighs, arms, hands, and trunk are sites of bruising which happen in the course of normal handling, childhood activity and play. However, many of these sites are also associated with abusive injury, and caution should be taken before accepting injuries as non-abusive. Histories from carers may need to be sought within the scope of multi-agency investigations.

7.2 The RCPCH fracture evidence review summary indicates that:

- Abusive fractures are more common in children less than 18 months of age than in older children
- Multiple fractures are more suspicious of abuse than non-abuse.
- Rib fractures in the absence of major trauma, birth injury or underlying bone disease have a high predictive value for abuse.
- Multiple rib fractures are more commonly abusive than non-abusive.
- Abusive femoral fractures are more likely to arise in children who are not yet walking.
- Supra condylar humeral fractures in children are associated with accidental injury whilst the commonest abusive humeral fractures in children aged less than five years are spiral or oblique.
- Humeral fractures in those aged less than 18 months have a stronger association with abuse than humeral fractures in older children.
- Linear fractures are the commonest abusive and non-abusive skull fractures.
- Metaphyseal fractures are more commonly described in physical child abuse than in non-abuse.
- Pelvic, hand, feet and sternal fractures occur in physical abuse and appropriate radiology is required for their detection.

7.3 Burns and scalds

With regard to burns and scald injuries, the majority result from unintentional injury, with an estimated 10% secondary to maltreatment, with a ratio of neglect to physical abuse of 9:1.

- Scalds are the most common intentional burn injury, and contact burns the second most common.
- Abusive scalds most frequently involve immersion injury, with clearly demarcated edges in a glove and stocking distribution.
- Abusive scalds frequently involve the buttocks and legs and are frequently bilateral and symmetrical. There may be central sparing of the buttocks and of the popliteal fossa.
- Features of non-intentional scalds include irregular margin, asymmetrical and anterior distribution. Agents are often hot beverages that have been spilt.
- The most frequent sites for abusive contact burns are the trunk, upper arm, thigh and back of the hand.
- Abusive contact burns are often multiple, in comparison to unintentional burns that are generally single.
- Abusive contact burns are classically clearly demarcated, of universal depth, and can carry the shape of the implement used.
- The RCPCH published its updated Systematic review on Burns in August 2022. The key findings indicate that: The prevalence of abusive burns is estimated to be 5.3% – 14% of children admitted to burns units, highest for those aged 0 – 1 years. Children with abusive burns were found to be significantly younger than those with accidental burns. However, when compared to children referred to child protection medical teams for all causes of physical abuse, those with burns were significantly older and more likely to be boys.

7.4 Abusive Head Trauma

The RCPCH Child Protection Companion, Chapter 9: Recognition of Physical Abuse, as Updated December 2021, notes that Abusive Head Trauma (AHT) is the most common cause of death in physical abuse and is predominantly seen in children less than 2 years of age, most commonly in those less than six months of age.

- Infants with AHT can present with a variety of symptoms, ranging from poor feeding, lethargy, seizures, and respiratory difficulty. Not all infants are acutely ill, and some present, for example, with an increasing head circumference.

8 REFERRAL TO CHILDREN'S SOCIAL CARE

8.1 Bruising and injury in immobile infants is rare, therefore the finding of a bruise or injury in an immobile infant must result in an immediate consultation with the Children's Safeguarding Lead for the professional's organisation.

A referral should be made to Childrens Social Care unless:

- the professional is aware that the bruise or injury has been previously documented and noted as being due to a medical condition or birthmark
- a bruise or injury has been witnessed by a professional and was accidental
- there is no concern about plausible explanation from a parent or carer, there must be no concern regarding the explanation for the bruise or injury or the presentation circumstances

For all the above to apply this must be in the absence of any other previous safeguarding concerns regarding the infant or family. (Bruising and suspected non-accidental injuries (NAI) in pre-mobile infants and non-mobile children 11)

8.2 It is the responsibility of the first professional to learn of, or observe, the bruising or injury to immediately consult with their Children's Safeguarding Lead within their service and consideration given to making a referral to Children's Social Care. However, this requirement should not prevent an individual professional of any status referring to Children's Social Care any child with bruising or injury who in their judgement may be at risk of child abuse.

8.3 If a referral is not made, reasons must be documented in detail with the names of the professionals taking this decision with relevance to this protocol and the exclusion criteria. (Point 1.5)

8.4 Referrals must be made to the Children's Social Care, Wandsworth MASH team or according to the area where the family reside if outside Wandsworth. mash@wandsworth.gov.uk Telephone 02088716622. All telephone referrals must be followed up in writing immediately. Children's Social Care will co-ordinate multi-professional information sharing and assessment. Professionals should provide as full a description as possible of the circumstances of the presentation, and of any marks identified.

8.5 It is the responsibility of the referring practitioner to follow up the referral to Children's Social Care by the end of the next working day.

9 WORKING IN PARTNERSHIP WITH PARENTS OR CARERS

9.1 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 could be destroyed) or if it would pose a further risk to the child.

9.2 It should be explained to parents at an early stage why in cases of bruising and suspected NAI in non-independently mobile children, additional concern, questioning, and examination are required.

9.3 Ensure that parents/ carers are given relevant verbal and written information (including a leaflet where possible) when a decision to undertake a CPME has been made.

9.4 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. Professionals should also consider their own safety at this time and involve the police immediately if any danger is present to themselves or others

10 REFERENCES

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