Berkshire

Bruising in Children who are Not Independently Mobile

A Protocol for Assessment, Management and Referral by Health Practitioners

Aim of protocol

The aim of this protocol is to provide frontline and senior health professionals with a knowledge base and action strategy for the assessment, management and referral of children who are NOT Independently Mobile (NIM) who present with bruising or otherwise suspicious marks.

It does not reiterate the process to be followed once a referral to Children's Social care has been made. For this, practitioners must consult the Berkshire Safeguarding Children Boards Child Protection Procedures available at: http:// www.proceduresonline.com/

Target Audience: All front line clinical staff: general practitioners including sessional doctors, locums and GP trainees; primary care staff including practice nurses; health visitors, district nurses, school nurses and midwives; community staff allied to medicine; clinicians in GP out of hours services, walk-in Centres, minor injury units and emergency departments; all community and hospital paediatric clinical staff.

Date for Review: August 2017

1. Introduction
Any bruising in a non-independently mobile child is unusual

1.1 Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews and individual child protection cases across Berkshire have indicated that clinical staff have sometimes underestimated or not recognised the highly predictive value, for child abuse, of the presence of bruising in children who are not independently mobile (those 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.

1.2 NICE guideline 89, When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009) states that bruising in any child not independently mobile should prompt suspicion of maltreatment. See: www.guidance.nice.org.uk/CG89

1.3 In the light of these findings a joint protocol has been developed for all health practitioners, for the assessment and management of bruising in children who are not independently mobile and the process by which such children should be referred to Children's Social Care and at the same time, to a consultant paediatrician for further assessment and investigation of

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potential child abuse. This protocol has been adapted from the approved protocol by the Hampshire, Southampton, Portsmouth & IOW LSCBs.

1.4 In light of NICE guideline 89 and the research base outlined in section 3 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 by requiring that **all children with bruising who are not independently mobile be referred to Children's Social Care and for a consultant paediatric opinion.**

2. Definitions

2.1 **Not Independently Mobile**: a child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Includes all children under the age of six months.

2.2 **Bruising**: extravasation of 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. This includes petechiae, which are red or purple non-blanching spots, less than two millimeters in diameter and often in clusters.

3. Research base

3.1 There is a substantial and well-founded research base on the significance of bruising in children. See **www.nspcc.org.uk** .

3.2 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. Innocent bruises 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 or soles,

3.3 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

3.4 **A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. A full clinical examination and relevant investigations must be undertaken.**

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3.5 **The younger the child the greater the risk that bruising is non-accidental and the greater potential risk to the child.**

4. Scope of Protocol

4.1 Any bruising, or what is believed to be bruising, in a child of any age that is observed by, or brought to the attention of, a health professional should be taken as a matter for inquiry and concern. This protocol relates only to bruising in children who are not independently mobile, that is to say children who are not yet crawling, shuffling, pulling to stand, cruising or walking independently.

4.2 It is not always easy to identify with certainty a skin mark as a bruise. Practitioners should take action in line with this protocol if they believe that there is a possibility that the observed skin mark could be a bruise or could be the result of injury or trauma.

4.3 While accidental and innocent bruising is significantly more common in older mobile children, health professionals are reminded that mobile children who are abused may also present with bruising (Baby Peter Connelly, 2008). The health professional 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.

4.4 Immobility, for example due to disability, in older children should particularly be taken into account as a risk factor. Disabled children have a higher incidence of abuse whether mobile or not.

5. Emergency Admission to Hospital

5.1 Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be referred immediately to hospital.

5.2 Such a referral should not be delayed by a referral to Children's Social Care, which, if necessary, should be undertaken from the hospital setting. **However it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Social Care has been made**

5.3 It should be noted that children may be abused (including sustaining fractures, serious head injuries and intra-abdominal injuries) with no evidence of bruising or external injury.

6. Referral to Children's Social Care

6.1 **In not independently mobile children, the presence of any bruising, of any size, in any site should initiate a detailed examination and inquiry into its explanation, origin, characteristics and history. The child should then be referred to Children's Social Care**.

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6.2 In the case of newborn infants where bruising may be the result of birth trauma or instrumental delivery, professionals should remain alert to the possibility of physical abuse even in a hospital setting. In this situation clinicians should take into account the birth history, the degree and continuity of professional supervision and the timing and characteristics of the bruising before coming to any conclusion. It is particularly important that accurate details of any such bruising should be communicated to the infant's general practitioner, health visitor and domiciliary midwife as well as accurate documentation in the child's personal child health record (red book). **Where practitioners are uncertain whether bruising is the result of birth injury they should refer immediately to the duty consultant paediatrician.**

6.3 **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.**

6.4 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 Children's Social Care any child with bruising who in their judgement may be at risk of child abuse.

6.5 If a referral is not made, the reason must be documented in detail with the names of the professionals taking this decision.

6.6 **Children's Social Care should take any referral made under this protocol as requiring further multi-agency investigation and should contact the consultant paediatrician, to whom referral is made under paragraph 6.1, for a medical opinion before reaching any conclusions on the case.**

6.7 Referral should, in the first instance, be made by phone:

During office hours (09.00 – 17.00)

Bracknell:	01344 351582
Reading:	0118 9373641
Royal Borough of Windsor & Maidenhead:	01628 683150
Slough:	01753 690898
West Berkshire:	01635 503090
Wokingham:	0118 9088002

At all other times (including weekends and over Bank Holidays)

Emergency Duty Team: 01344 786543

6.8 All telephone referrals must be followed up within 48 hours with a written referral, using the appropriate Interagency Referral Form and must be fully documented in the patient records.

6.9 The referrer should record the joint action plan agreed with Children's Social Care including any health follow-up.

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7. Referral for a Paediatric Opinion

7.1 When a child is referred to Children's Social Care under this protocol, a referral should also be made to the duty paediatric consultant for an assessment of the bruise or mark and a detailed physical examination of the child. This should be undertaken by the acute paediatric team or the community paediatric team depending on local practice.

7.2 For a paediatric opinion contact please contact the duty paediatrician at the local hospital to agree where to take the child:

Frimley Park Hospital, Telephone 01276 604604
Royal Berkshire Hospital, Telephone 0118 3225111
Wexham Park Hospital, Telephone 01753 633000

7.3 **The referral should be made, and the child seen, on an urgent and immediate basis.** The parent/carer transporting the child to hospital must be informed that they are expected to attend hospital within a maximum of two hours. It is the responsibility of Children's Social Care receiving the referral to ensure that the child reaches hospital. If necessary a social worker should assist the family to get to the assessment.

7.4 The duty paediatric consultant (or associate specialist) or their delegate, must liaise with Children's Social Care with regard to the outcome of the assessment as soon as it is completed.

7.5 Where a referral is delayed for any reason, or where bruising is no longer visible, a consultant paediatrician, or their delegate, 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.

8. Involving Parents or Carers

8.1 As far as possible, parents or carers should be included in the decision-making process unless to do so would jeopardise information gathering or pose a further risk to the child.

8.2 In particular professionals should explain at an early stage why, in cases of bruising in not independently mobile children, additional concern, questioning and examination are required. The decision to refer to a paediatrician, and to Children's Social Care, should be explained to the parents or carers frankly and honestly. The child's parent/ adult carer should be given the agreed documentation to take with them to hospital and the explanatory leaflet (available to download separately).

8.3 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. If possible the child should be

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kept under supervision until steps can be taken to secure his or her safety.

9. Innocent Bruising

9.1 It is recognised that a small percentage of bruising in not independently mobile children will have an innocent explanation (including medical causes). Nevertheless because of the difficulty in excluding non-accidental injury, practitioners should seek advice from a consultant paediatrician and from Children's Social Care in all cases.

9.2 It is the responsibility of Children's Social Care in conjunction with the Paediatrician to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not.

9.3 In general practice any history of bruising should be flagged as a significant problem/risk factor in the notes.

9.4 Occasionally spontaneous bruising may occur as a result of a medical condition such as a bleeding disorder, thrombocytopenia or meningococcal or other acute infection. **Child protection issues should not delay the referral of a seriously ill child to acute paediatric services.**

9.5 Practitioners should take into consideration cultural practices and racial characteristics when assessing bruising, including communication difficulties. However no cultural practice should harm a child.

10. Sharing Information and Consulting Colleagues

10.1 The case and findings should be shared and discussed with another professional or senior colleague. Child protection issues are necessarily complex and seeking advice from a colleague protects against professional optimism and promotes safe practice.

10.2 In primary care a general practitioner should notify and discuss the findings with the child’s health visitor and vice versa.

10.3 In the general practice out of hours service such a discussion should take place either with the clinical director of the service, or with a senior colleague.

10.4 In the hospital emergency department, the discussion should be with the most senior clinical colleague available.

10.5 Staff should seek advice or discuss the case with their Area (primary care) or Trust (acute/community trusts) Safeguarding Children's Team but, if unavailable, should not delay referral.

10.6 An individual practitioner must not be afraid to challenge the opinion of a colleague if they believe in their own judgement that a child might be at risk of harm.

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10.7 Whenever possible, the child's parent or carer should be informed before sharing confidential information. However if this would incur delay, or if to do so would put the child or the professional at risk, then practitioners can be reassured that confidential information may be lawfully shared if it can be justified in the public interest (*Information Sharing: Guidance for Practitioners and Managers HM Government 2008*). “The public interest” includes belief that a child may be suffering, or be at risk of suffering, significant harm. (*Working Together to Safeguard Children, HM Government 2015*)

11. Paediatric Assessment

11.1 A cogent and credible explanation for the bruising should be sought at an early stage from parents or carers and recorded. It is important to undertake this with open questioning and to avoid leading questions.

11.2 The lack of a satisfactory, or consistent, explanation or an explanation incompatible with the appearance or circumstances of the injury, or with the child’s age, or stage of development, should raise suspicions of abuse.

11.3 If possible history should be sought from more than one carer separately or more than once from the same carer. Inconsistencies or variations between carers or between interviews should raise suspicions of abuse.

11.4 A full physical examination of the completely undressed child should be undertaken. This should include weighing, observation of general demeanour, cleanliness, infestations, nourishment and body proportion, as well as looking for other bruising or evidence of injury. If available, the child’s growth chart should be examined.

11.5 A review of the child's medical history, including any previous occurrence of bruising or injury, should be undertaken and, in general practice, the health visiting records examined. Consideration should be given to identified vulnerabilities within the family such as domestic abuse, substance misuse, mental health issues and deliberate self-harm. All information should be included in the referral to Children’s Social Care and the paediatrician.

11.6 Where a history of previous child protection concerns is given by Children's Social Care this information must be recorded in the health record.

11.7 In all cases careful mapping, description and recording of the size, colour characteristics, site, pattern and number of the bruises should be made and a careful record of the carers/parents description of events and explanation for the bruising made in the clinical notes.

11.8 **The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be overemphasized.**

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12. Other Sources of Guidance and Information

Berkshire Local safeguarding Children Boards Child Protection Procedures
http//www.proceduresonline.com/

Working together to Safeguard Children, HM Government, 2015 **http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/**

What to Do If You Are Worried a Child Is Being Abused, HM Government, 2015
http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182/

Child Protection Companion, Royal College of Paediatrics & Child Health, April 2008 When to

Suspect Child Maltreatment (NICE Clinical Guideline 89, July 2009)
http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English

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NHS
Berkshire

REFERRAL TO HOSPITAL CONSULTANT PAEDIATRICIAN IN LINE WITH NHS BERKSHIRE BRUISING PROTOCOL

To: …………………………………………………………..

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Dear Doctor……………………………………………………

The child named below has been referred to hospital in line with the NHS Berkshire Bruising Protocol. The referral has been discussed with Children's Services and the relevant Social Worker is named below.

Signature: …………………………………………………….. Designation: ………………………………………………..

Print Name: ……………………………………………………

DATE & TIME OF REFERRAL: ………………………………………………………………………………………………………..

Child's name: …………………………………………………………… DOB: …………………………………………………..

Address: ……

Telephone Number:……………………………………………………

Social Worker: ………………………………………………………. Telephone number……………………………..

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DATE & TIME OF REFERRAL: ……...

Child's name: …………………………………………………………… DOB: ……………………………………………………..

Address: ...……

Telephone Number:………………………………………………….

Social Worker: ………………………………………………………. Telephone number……………………………..

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