SBNI Protocol - BRUISING/MARKS (WHICH COULD BE DUE TO INJURY) ON PRE-MOBILE BABIES

Frequently Asked Questions

What is this protocol?	**The key principle of the protocol is that any pre-mobile baby found to have bruising/marks (which could be due to injury) which cannot be explained by previous treatment and care provided by health professionals (including bruising/marks arising from birth trauma should be referred immediately to a hospital based senior paediatrician for a comprehensive assessment.** **Professionals should make every effort to clarify and verify the detail of previous medical treatment and care such as seeking information from body maps/written documentation held in the child's health record.** **If the senior paediatrician confirms this bruising/mark is an injury (not caused by previous treatment and care provided by health professionals including birth trauma) then multi-disciplinary discussion including enquiry and exchange of information with children's social services must take place regardless of whether or not there is an accidental explanation consistent with the clinical findings.** **The aim is to provide a consistent approach across NI.**
What is meant by a mark which could be due to injury?	**Any visible mark on the body, which is either reported to be due to an injury or in the judgement of the referring professional, could be caused by an injury. This therefore requires assessment by a Senior Paediatrician under this PMB Protocol.**
Why is this needed?	**Bruising is the most common presenting feature of physical abuse in children.** • **Minor bruising in infants (described as sentinel bruising [1]) can be followed later by severe physical abuse.** • **In a study of 401 infants evaluated for abuse - of 200 definitely abused infants (abusive head trauma, abdominal trauma, burns or fractures) 27.5% had a previous sentinel injury with bruising accounting for 80% of those injuries[2].** **Although bruising is not uncommon in older, mobile children, it is rare in infants that are pre-mobile, particularly those below age six months. While up to 60% of older children who are walking have bruising, it is found in less than 1% of infants who are not independently mobile[3].** **SBNI CMR Francis** http://www.safeguardingni.org/sites/default/files/sites/default/files/imce/francis_01_2016.pdf

To which staff does this protocol apply?	**This protocol is relevant for all health and social care professionals (including Allied Health Professionals and GP's). The protocol is collaborative in nature and sets out the need for communication and information sharing between key professionals involved, namely paediatrician, referral agent, nursing staff, hospital and/or gateway social worker/current social worker, the health visitor, family nurse, midwife where relevant and GP.**
To which babies does this protocol not apply?	• **Babies who are mobile.** • **Pre-mobile babies for whom the nature of the injury clearly suggests physical abuse. In these cases the Core Regional Policies and Procedures should be initiated and not the PMB Protocol. http://www.proceduresonline.com/sbni/** • **Pre-mobile babies where the mark is a birth mark.** 1. **When a health professional is sure the presenting mark is a birth mark- no further action is required under this protocol. However, in the case of a Mongolian blue spot they should still ensure diagnosis has been confirmed by a medical practitioner either previously or the baby should be seen by the GP preferably within 2 hours (i.e. normal timescales of protocol). Any exception to this needs agreed between the referrer and the GP but should be within 24 hours** 2. **If a health professional suspects a birth mark but requires a medical opinion, the baby should be seen by the GP preferably within 2 hours (i.e. normal timescales of protocol). Any exception to this needs agreed between the referrer and GP but should be within 24 hours** 3. **If further medical opinion is required this should be discussed with a senior paediatrician and the PMB protocol should be initiated if the nature of the mark remains unclear (injury remains a possibility) and paediatric assessment required.** • **Other clinical findings, as a result of the birth process, which may not have been evident at discharge.**
What about babies who are rolling?	• **One study published in 2014 showed 6.7% of pre-mobile babies surveyed had at least one bruise (2.2% of babies who could not roll over and 9.8% in those who could roll over)[3].** • **Bruising is therefore unusual in those who cannot roll.** • **Babies who are not actively rolling as a means of mobility (including those only able to flip from back to front) should be considered as pre-mobile and should be referred under the protocol.** • **Babies who can roll actively for mobility should be considered as mobile and should not be referred under the protocol. (Remember**

	in any child with bruising SBNI Regional Core Policies and Procedures must be initiated if the nature of the injury clearly suggests physical abuse).
What about pre-mobile babies in whom incidents are reported?	• **Any visible signs of injury e.g. haematoma/skin redness /abrasions/lumps/bumps should be referred under the PMB protocol.** • **Where there is a report of an incident but there are no visible signs, professional judgement should be applied and advice sought if necessary.**
What if an older child is pre-mobile as a result of developmental delay?	**This will require professionals to make a judgement regarding the need to initiate SBNI Core Regional Policies and Procedures i.e. if physical abuse is suspected. Advice can be sought from line managers/safeguarding leads i.e. SCNS/Senior Paediatrician/Named Nurse.**
When should the Referral Form for Hospital Paediatric Assessment be used?	**Relevant information should be discussed verbally with the senior paediatrician and followed up with a written referral. A suggested referral form is provided. This can then be sent electronically according to local arrangements. The referral form should be used by community based professionals i.e. HV/Midwife/Family Nurse.** **It is unlikely that this referral form will be completed by hospital based staff unless the additional information is known to them.**
What if parents /carers refuse to co-operate?	**Obviously it is best for families to work in partnership with professionals involved in a co-operative and open manner. However, if a parent/carer refuses to co-operate advice should be sought immediately from direct line managers in terms of how this should be progressed and if necessary SBNI Core Regional Policies and Procedures should be initiated with immediate telephone referral to children's social services and completion of a UNOCINI referral form within 24 hours (unless otherwise directed by children's social services).**
How quickly should the baby attend hospital?	**Parents/carers should be advised to attend hospital within 2 hours. Any exception to this needs agreed between the referrer and senior paediatrician but should be within 24 hours. The parents/carers should be advised that they may not be seen immediately on arrival, depending on the particular case and the ward environment at the time. They should also be advised that admission may be required in some cases if investigations are needed.**

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Where does the baby attend?	**The baby will attend the local paediatric unit and will not usually require attendance via an Emergency Department.**
Does the referral agent attend with the baby?	**In most cases this will not be necessary. However, the referrer will need to use professional judgement in terms of whether they need to accompany or follow the baby to hospital. This will depend entirely on the specific case and knowledge of the family and their ability to access transport etc.**
What is a senior paediatrician?	**A paediatrician working at middle grade level or above, with relevant Level 3 plus child protection competencies as outlined in *"Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019".* Whilst such a doctor can assess the baby all cases must (at the very least) be discussed with the supervising Consultant Paediatrician who must sign off the paediatric assessment outcome form.**
What if parent/carer provides a reasonable explanation?	**Whilst the explanation may seem plausible the protocol stipulates the need for Multi-disciplinary discussion if injury is confirmed on Paediatric assessment. The individual making the referral should share their professional view with the paediatrician.**
What if parent/carers have no plausible explanation but the Consultant Paediatrician considers an accidental cause which in their opinion is consistent with the injury?	**In this situation, the Consultant Paediatrician should discuss their opinion with a Safeguarding Paediatrician for advice on the clinical findings and whether there remains a child protection concern. If no Safeguarding Paediatrician is available then the case must be discussed with a second Consultant Paediatric colleague. Where there is a child protection concern SBNI Core Regional Policies and Procedures should be initiated with immediate referral to children's social services and completion of a UNOCINI referral form within 24 hours (unless otherwise directed by children's social services).**
Will all marks/bruises assessed at hospital need photographed?	**Yes - it is considered important to document all marks assessed under the protocol so an accurate record is available in the event of any further queries regarding the nature of the mark/bruise. Consent must be sought from a person with parental responsibility to photograph the mark.**
Will all babies require a full skeletal survey and investigations?	**The decision to carry out a skeletal survey or any other medical investigations will be made by the consultant paediatrician taking into account all the information available.**
How should parent/carer contact with the baby be managed on the ward during admission?	**Issues in relation to parent/carer contact with the baby and any safeguarding concerns about other children in the family should be considered in line with the SBNI Core Regional Policies and Procedures.**

What if any of the professionals involved disagree about the cause of the bruising/mark?	**If there is professional disagreement, a meeting of the core disciplines involved should be convened immediately to agree a way forward. This meeting should be chaired by the Consultant Paediatrician unless social services are involved.**
When can a baby assessed under this protocol be discharged?	**Babies considered under this protocol in whom there is bruising/injury and no accidental explanation consistent with the clinical findings must not be discharged from hospital until the relevant examinations, investigations and all available multi-disciplinary information has been shared and analysed; except in some circumstances they may be discharged with arrangements in place to ensure the baby's safety agreed between carers and the core disciplines involved (especially social services) whilst awaiting completion of investigations.**

References: -

[1]**Sentinel Injuries in Infants Evaluated for Child Physical Abuse** Lynn K. Sheets, Matthew E. Leach, *Pediatrics* 2013;131;701

[2]Sugar NH, Taylor JA, Feldman KW (1999) **Bruises in infants and toddlers; those who don't cruise rarely bruise.** Puget Sound Pediatric Research Network. *Archives of Pediatrics & Adolescent Medicine*; 153(4):399–403

[3]Patterns of bruising in preschool children—a longitudinal study. Kemp AM, et al. Arch Dis Child 2015;0:1–6. doi:10.1136/archdischild-2014-307120