SET MULTI-AGENCY PROTOCOL

Management of Suspicious / Unexplained Injuries / Bruising in Children for all Front-Line Professionals

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Status:	*Agreed by the SET Procedures Working Group December 2018* **Note: This is being rolled out across the county and we advise that you check it is implemented in your area.**

SUMMARY OVERVIEW

If you do have concerns:

All professionals

Any bruise/mark on a child should be considered in light of the history provided; location of the bruise/mark; and the age and developmental stage of the child/infant.

If the child is under 6 months of age; not independently mobile; or under 18 years of age and there is suspicion of non-accidental injury; the professional must refer the child/family into Children's Social Care, following Southend, Essex and Thurrock Child Protection and Safeguarding Procedures

Health/Medical professionals ONLY

If the child/infant is under 6 months of age, and/or immobile, Health/Medical professionals may use the pre-assessment tool (Appendix 2) to assist in an assessment of the bruise/mark. If in any doubt the professional must refer the child/family into Children's Social Care, following local processes/SET Procedures.

If you have no concerns:

If there are no concerns, and you are in agreement that the history given is consistent with the bruise/mark observed; the child's developmental age; and mobility; ensure you:

- Review all previous records for any similar history or risk factors;
- Review the distribution of bruising document (Appendix 3);
- Document your observations and what has been reported by the **child** (all information) in the child's records;
- Document your observations and what has been reported by **parent/carer** (all information) in the child's records;
- Document clearly bruising/marks observed on a body map (Appendix 4) and record in the child's record and Parent Held Record;
- Consider safety assessment and advice to prevent further incident;
- Share relevant information with Health Visiting/School Nursing Service and GP.

This document should always be read in conjunction with the flow chart (Appendix 1) and with Southend, Essex and Thurrock Safeguarding and Child Protection Procedures which can be found here

Aim of this protocol

The aim of this Protocol is to provide frontline professionals with a knowledge base and clear action strategy for the assessment, management and referral of children under the age of 18 who present with bruising and/or suspicious marks.

The Protocol is necessarily directive in term of actions to be taken, and whilst professional judgement and responsibility is recognised as important, research tells us we must act at all times where there are concerns. Therefore we require that a referral to Children Social Care is undertaken and the child examined by an appropriate Paediatrician for a Child Protection

Medical on **all** children who are seen to have bruising/marks who are under 6 months or who are not independently mobile, and in any child under 18 where suspicious bruises/marks are identified.

Introduction

Non-accidental injuries are injuries that are suspected or proven to have been inflicted upon a child by someone else, or in the care of someone else. Any bruising, fractures, bleeding and any other injuries (such as burns) should be treated as a matter for enquiry and potential abuse considered, unless otherwise evidenced[1]. An injury should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and the explanation given.

Bruising is the most common presenting feature of physical abuse in children, however it may also be as the result of the child experiencing other forms of abuse such as neglect or sexual abuse. Serious case reviews nationally, and individual cases across Southend, Essex and Thurrock highlight that frontline staff sometimes underestimate or ignore the prediction that abuse is a likely cause of bruising in young babies who are not independently mobile (those not yet crawling, cruising or walking independently or children with disability such that they are not mobile).

NICE guidance[2] states that bruising in any child who is not independently mobile should prompt suspicion of maltreatment as these children are the least likely to sustain accidental bruises

Whilst bruising in older children is much more likely to be presented, it is vital that these are assessed in terms of the history, risks factors, medical factors, social development, disability and what research tells us about non-accidental bruising. Where there are concerns about a mark or bruise the decision that the child **has not** suffered abuse should always be a multi-agency decision and not one made by a single agency[3].

Target Audience

Front line practitioners:
This includes, but is not exhaustive, teachers and staff in specialist education provision, GPs, Nurses, Midwives, Health Visitors, Allied Health professionals, disabled children's workers, Nursery Nurses, School Nurses, Early Years Professionals, Youth Workers, Police, Emergency Department staff and Minor Injuries/Urgent Care Centre staff, Paediatricians, Voluntary and Community Workers and Social Workers.

The UK Government states that 'Whilst local authorities play a lead role, safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play[4].

[1] https://www.nice.org.uk/guidance/cg89
[2] https://www.nice.org.uk/guidance/cg89
[3] https://www.ncbi.nlm.nih.gov/pubmed/20926622
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf

Underpinning Research

Bruises:

NICE guidance [5]outlines the following:

Suspect child maltreatment if a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable. Examples include:

- *bruising in a child who is not independently mobile*
- *multiple bruises or bruises in clusters*
- *bruises of a similar shape and size*
- *bruises on any non-bony part of the body or face including the eyes, ears and buttocks*
- *bruises on the neck that look like attempted strangulation*
- *bruises on the ankles and wrists that look like ligature marks or holding/restraint marks.*

Bruises are unusual in babies under 6-months-old who are unable to sit or crawl. Once infants develop mobility, the frequency of accidental bruises steadily rises from approximately 10% of those who can sit to 40% of those who can walk. These bruises are usually <1 cm in diameter, often over the forehead, bony part of the cheek or jaw, or shins. An active baby in the first 18 months might have two or perhaps three of this type of bruise at the same time.

In older children, most accidental bruises are over bony prominences and sometimes associated with a graze. Between 18-months and 3-years, forehead and facial bruises (over bone) are common (17% of children) but unusual in older children. Accidental bruising of the hands and feet and lower legs (particularly the shins and often multiple) are frequent. 14% of children 6-11 years have bruises over the lower back but bruises at this site are unusual under the age of three years. An active boisterous child may have up to 12 accidental bruises at these sites.

Non-accidental bruises are more likely to be around the mouth and adjacent cheek, neck, eye-socket, ear, chest, abdomen, upper arms, buttocks and upper legs. All these areas are relatively protected. Some bruises have a particular configuration, such as a slap, fingertip bruises, pinch marks or marks from an implement. Non-accidental bruises are usually multiple and cannot easily be explained on the basis of simple falls. Maguire[6] clearly illustrates accident versus abuse bruising patterns (Appendix 4)

When the nature of the bruise does not differentiate non-accidental from accidental injury, the key issue is the discrepant history where there is either no explanation or an inadequate explanation. Full assessment usually requires a strategy meeting.

Serious Case Reviews highlight the child who presents with severe or repeated bruising where the parent forestalls an investigation by suggesting bullying, a fall, self-injury and injury

[5] https://www.nice.org.uk/guidance/cg89
[6] https://www.ncbi.nlm.nih.gov/pubmed/20926622

from siblings. Bruising from bullying (including bigger teenage siblings) requires investigation, accidents are liable to produce bruises on exposed bony surfaces along with grazes, self-injury is rare and pre-teen siblings are not usually strong enough to produce significant bruising.

Presentation

Bruising which suggests the possibility of Non-Accidental Injury include:

- Bruising in babies (in arms - research has shown a small bruise on a pre-mobile baby can be a sign of abuse)
- Bruising in children who are not independently mobile (including disabled children)
- Bruises that are seen away from bony prominences
- Bruises around mouth & cheeks, back, abdomen, upper arms, buttocks & ear lobes.
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry an imprint – of an implement, cord or hand/foot
- Bruises with *petechiae* (dots of blood under the skin) around them

A mark/bruise should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given (See appendix 4)

A full clinical assessment and relevant investigation must be undertaken and should include:

- The nature and site of injury
- The history provided by the child and accompanying adult
- The plausibility of the explanation given
- The timing/age of the alleged injury and any delay in seeking attention for which there is no satisfactory explanation
- The child's appearance, behavior and demeanour
- The child's development
- The interaction between parent and child
- The family and social circumstances and other relevant information available on the child's records

An explanation for an injury or presentation must be considered **unsuitable** if implausible, inadequate or inconsistent[7]:

- With the child (presentation, normal activities, existing medical condition, age or developmental stage, account compared to that given by parent
- Between parents
- Between accounts over time
- Based on cultural practice

Risk factors

When making an assessment and referral you should always review the information you hold within your agency with regards to the family and child to identify any relevant and associated risk factors that you will need to share with the social worker. This may include parental risk factors or child risk factors.

[7] https://www.nice.org.uk/guidance/cg89

Emergency medical conditions or injury

Any child who is found to have suspicious bruises or marks **and** is seriously ill or injured, or in need of urgent treatment or investigation, should be immediately referred to hospital. Professionals should be particularly diligent to the age of the child as the smaller the child, the greater the risk of internal injury.

Referral to hospital should not be delayed by a referral to Children's Social Care as this can be made from the hospital setting although **it is the responsibility of the person dealing with the case to ensure this referral has been made and also to phone ahead to the hospital to advise regarding the concerns** (see telephone numbers).

Referral to the emergency department if you have an immediate medical concern.

- CALL 999 AND REQUEST AN EMERGENCY AMBULANCE
- If it is not a life-threatening emergency and you ask the parents to take their child to the hospital because there is an immediate medical concern ensure you phone ahead to the agreed nearest children's emergency department (see below) to ensure they are aware what the reason is for attendance and also, so they can feedback on the child's attendance.
- Consider transfer by ambulance in all situations, especially for babies under 12 months of age.

Contacting Emergency Departments:

Hospital	Contact numbers
Basildon & Thurrock University Hospital	01268 524900
Broomfield Hospital, Chelmsford	01245 362000
Colchester Hospital	01206 747474
Princess Alexandra Hospital, Harlow	01279 444455
Southend Hospital	01702 435555

Request support from children's social care - by any agency

In children 6 months and under and non-independently mobile children (due to age or disability) the presence of any bruising of any size and in any site should initiate an immediate referral to Children's Social Care under this protocol and the referral directed to Essex Police.

In mobile children the presence of suspicious marks or bruising or following a disclosure from the child, should be referred immediately to Children's Social Care without delay. Sometimes this means that professionals may work together to make the decision, but this should not delay the process or prevent any professional of any status making this referral.

Prior to making a referral, the professional should ensure that they have sufficient information to assist Children's Social Care in responding to the concerns. 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 to that agency. It is good practice to inform the parent/carer that a referral will be made to Children's Social Care, unless this is going to place the child at greater risk[8]

Roles and Responsibilities of agencies

Maternity services

Following delivery all naturally occurring skin blemishes and/or visible marks (e.g. Mongolian Blue Spot, Strawberry Nevus) and those which may have occurred as a result of an assisted delivery or birth trauma should be clearly documented on a body map along with a description of how the mark occurred.

Children's services

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

If the child/ren already has a Social Worker, Children's Social Care should ensure that the named Social Worker or a Duty Social Worker responds immediately and within one hour.

The decision regarding whether a Child Protection Medical is undertaken or not should be taken within a Strategy Meeting which health should be invited to, and a medical opinion sought. If the decision at the Strategy Meeting is that a Child Protection Medical is not required, the Social Worker should consider the medical needs of the child, following discussion with relevant health professionals, and ascertain whether a medical assessment is still required.

Police

The Police, on receipt of a referral made under this protocol, will conduct a review to consider the need for any immediate safeguarding measures to be implemented in order to safeguard the child(ren) involved.

The Police will take any referral made under this protocol as requiring further multi-agency investigation. The Police will notify partner organisations of the referral (if not already aware) and the requirement for a strategy discussion as defined in Working Together 2018.

The Police will, in preparation for the Strategy Discussion, collate all available information to share with partner organisations under statutory framework or existing information sharing agreements.

The Police will actively participate in Strategy Discussions and undertake such actions to ensure the safety of all identified children and if deemed appropriate secure and preserve evidence in accordance with legislation and best practice.

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

Health / medical professional referral for paediatric assessment by a suitably qualified paediatrician

This Protocol has provision for the health professional to refer the child directly for paediatric assessment, following referral to Children's Social Care.
Consideration must be given to establish if the parents may take the child for the examination unaccompanied by other professionals and how the child will be transported to the Hospital.
In localities where direct referral is not available, professionals must refer to Children's Social Care requesting onward referral for paediatric assessment.

Hospital	Contact numbers
Basildon & Thurrock University Hospital	01268 524900
Broomfield Hospital, Chelmsford	01245 362000
Colchester Hospital	01206 747474
Princess Alexandra Hospital, Harlow	01279 444455
Southend Hospital	01702 435555

Health / Medical professionals **only** can make their assessment of marks based on professional knowledge of normal manifestations, birth injuries and marks on new babies. Where practitioners are uncertain whether bruising is as a result of birth injury or whether a mark is indicative of a birth mark they should always first refer to and speak with relevant Children's Health Providers (as above) and then refer immediately and directly to the Paediatrician for an assessment.

Child Protection Medicals

Social worker referral for child protection medical
The decision to undertake a Child Protection Medical should be the result of a Strategy Meeting/Discussion unless there is an immediate or urgent (high risk) need requiring Hospital attendance. This decision should be reached jointly between Children's Social Care, Police and Health and a Strategy Meeting/Discussion should be arranged as soon as possible thereafter. The Social Worker should assist the family to attend the Child Protection Medical and must attend the Child Protection Medical with the child and parent/carer.

Following the Child Protection Medical, the Paediatrician who examines the child should liaise with the Social Worker regarding to the outcome of the assessment.

Where a referral for Child Protection Medical is delayed for any reason, or when bruising /mark is no longer visible a Named Paediatrician must still examine the child to assess, as a minimum, general health, signs of other injuries or maltreatment and to exclude any medical cause.

Child Protection Medical and Paediatric Assessment
If there is a medical emergency the child may have to be taken by ambulance to the nearest available hospital, however it is the referring professional's duty to ensure all information

around concerns are shared and highlighted to the receiving hospital for them to make an assessment. The referring professional should also inform their Safeguarding Lead and the Named Paediatrician/Named Doctor.

Transportation for a Child Protection Medical should always be discussed with Children's Social Care and an agreement made between the Social Worker and parent(s) regarding how the child should be transported to the hospital. The Social Worker may wish to also accompany the child and parent(s) to the Child Protection Medical following a risk assessment.

Non-attendance of the child at the Medical (either Child Protection or for paediatric assessment) should always be referred back to the assigned Social Worker for the case and Strategy Meeting again considered.

Cross border children

Children who are ordinarily resident outside Southend, Essex or Thurrock still come under the remit of this protocol and the fundamental principle of responding to suspicious marks and bruises remains and is a requirement of all professionals coming into contact with any child. Therefore, if there are concerns, a referral to Social Care in the child's local area is vital. It is the responsibility of the person who is dealing with the case to make the referral.

Involving parents and carers

Parents should be informed at an early stage about the progress of the decision making process and the reasons for this unless to do so will further jeopardise information gathering or pose a further risk to the child.

This should always be carried out sensitively and in a private place if possible to avoid further distress to parents / carers.

In non-independently mobile children or children less than 6 months it is important that professionals pay particular attention to explaining to parents, in a frank and honest way, why additional concern, questioning and examination is required. The decision to refer to Children's Social Care must be explained along with the referral process for medical assessment.

It is advised that children with suspicious marks or bruises or those that disclose abuse in pre-school or school settings when parents are not present that the referral to Children's Social Care is made **prior** to informing the parents and without further questioning of the child.

If parents refuse to co-operate or refuse to take their child or be available for further assessment this should be reported immediately to Children's Social Care and to the Police if there are concerns for the child or staff safety. In these cases, if at all 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.

Disabled children

Evidence that children with disabilities are at increased risk of suffering maltreatment is well documented. Professionals should ensure effective communication and should take into

account additional needs such as physical, sensory or learning disabilities, or the inability to speak or read English.

Disability as a factor, should not hinder the assessment or concerns around suspicious marks or bruises on children where a clear and satisfactory causative explanation cannot be found and especially if the child is not independent mobile

Diversity factors

Consideration should be given to cultural needs of children or young people and their families and carers, however cultural practices that are abusive are **never** an acceptable reason for child maltreatment.

Professionals should at all times be aware of and sensitive to any difficulties in communicating this protocol to parents/ carers and children. This may be due to learning difficulty/disability, language barriers, disability or poor understanding of legislation in the UK.

It is important that the child is seen as swiftly as possible and therefore indicative that additional support and provision is made to assist effective communication but this should not hinder immediate referral.

Escalation process

If you are concerned about the lack of response to a safeguarding concern from any agency you must discuss it with your Safeguarding Lead who will escalate it, as appropriate, in line with SET Safeguarding and Child Protection Procedures These can be found here http://www.escb.co.uk/media/1670/set-procedures-oct-2018-updated.pdf

Appendix 1:

Suspicious or Unexplained Injuries/Bruising in Infants and Children

Infant/child presenting with suspicious or unexplained injury AND *any* bruising in a pre-mobile infant (under 6 months old)

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Inform parents/carer duty to refer to On Call **Paediatrician** at Acute Hospital for further investigation **AND Local Authority Children's Social Care**

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Contact On Call Paediatrician at Acute Hospital and arrange review -

arrangements should include how the child is transported, who will be accompanying the child and which professional will be responsible for confirming attendance within the stated timeframe

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Refer relevant to Local Authority Children's Social Care (CSC)

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If safe to do so, child can be taken by parents/carer to Hospital

If immediate safeguarding concerns, child should be transferred by Social Worker or Police

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Confirm attendance with Acute Hospital as agreed

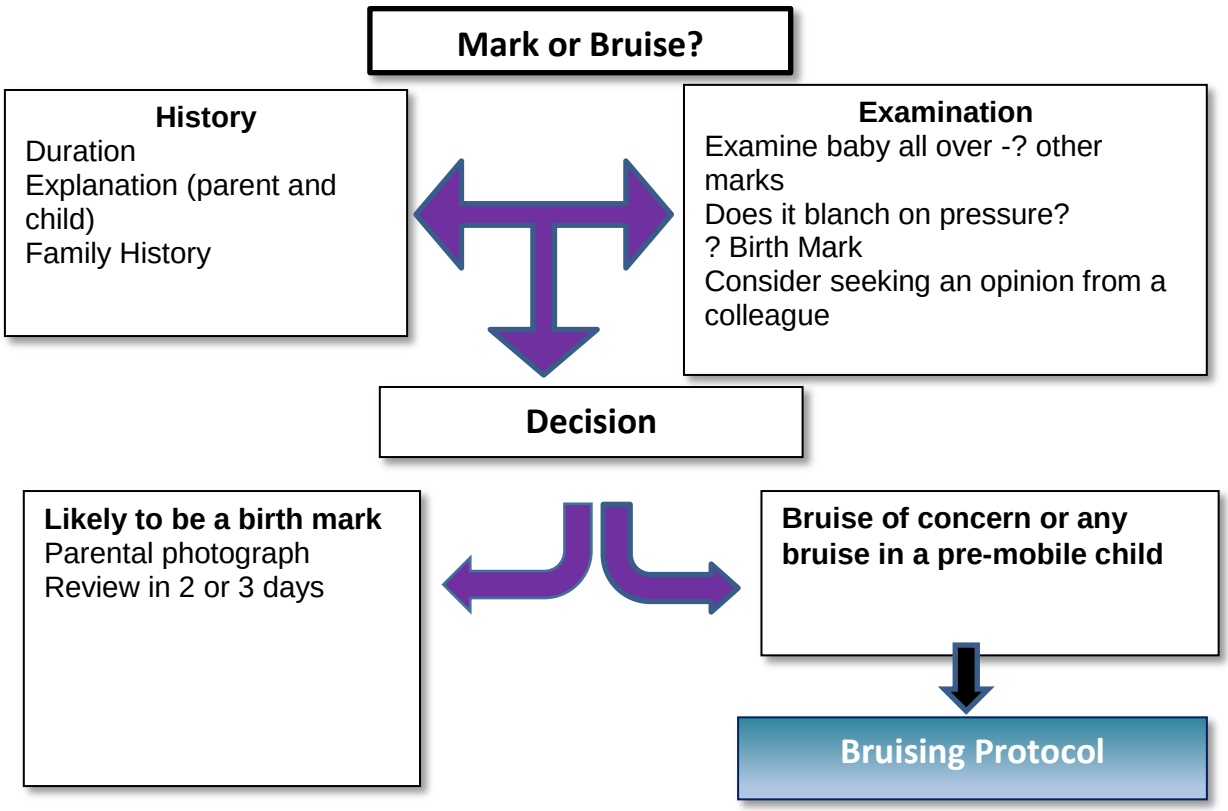
Recording

- Document who accompanied the infant /child
- Explanation provided by parent/ carer
- Full examination including body map of marks/blemishes/injuries/bruises
- Assessment, actions taken and rationale, including content of discussion with parent/carer
- Arrangements for transporting infant/child to Acute Hospital
- Confirmation child attended
- If a referral is **not** made, document rationale for this.

Red Flag – bruising/ injuries in non-mobile infants and children

Appendix 2 Assessment of Marks in Babies and Children Prelude to Unexplained and Suspicious Injury (Bruise) Protocol

Advice for front-line health professionals



Comments

- Mark present from birth or early life and persists – probably birth mark, observe if necessary.

- Mark in suspicious area, around mouth or eyes, on ear which you think is a bruise
- Any bruise in a pre-mobile infant (under six months old)
- Infant with nose bleed, mouth bleed
- Skin blister in newborn/ infant: probably staph infection
- Infant unwell or injured in any way

HOSPITAL

Points to observe

1. Mongolian blue spots are purple, present in sacral area and satellite spots.
2. No general welfare concerns + looks like a birth mark: safe to review.
3. In most cases of inflicted 'precursor' bruise, parents usually concede mark is a bruise but the explanation suggests unreasonable force, e.g. held wile feeding, or is implausible e.g. lying on dummy.

Appendix 3 – Distribution of Bruising Tool

The Distribution of Bruising, Accidental vs Non-Accidental document can be found by following this link.

http://www.escb.co.uk/media/1719/distribution-of-bruising-accidental-vs-non-accidental.pdf

Appendix 4 – Body Map

BODY MAP

Child's name:		
Date of birth:		
Date/time of skin markings/injuries observed:		
Who injuries observed by:		
Information recorded:	**Date:**	**Time:**
Name:		**Signature:**