Bruising in Children who are NOT Independently Mobile

Multi-Agency Protocol for the assessment, management and referral of actual or suspected bruising in children who are not independently mobile.
Bruising in Children who are Not Independently Mobile (3B Protocol)

A Protocol for the Assessment, Management and Referral of actual or suspected bruising

Aim of Protocol

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

The 3B Protocol is specifically directed at action by health professionals who encounter bruising in not independently mobile children. However, it is recognised that any professional who works with children and families may encounter bruising in not independently mobile children. As such, all personnel working in non-health organisations should be made aware of this protocol to ensure that the requirements of this protocol are fulfilled in the event that they are the first person to observe bruising.

Target Audience: All front line staff working with children and families or whose work brings them into contact with children; Contact and Referral Team professionals; Social Workers; Family Support Workers; Clinical staff i.e. general practitioners including sessional doctors, locums and GP trainees; primary care staff including practice nurses; health visitors, district nurses, school health advisers and midwives; community staff allied to medicine; clinicians in GP out of hours services, urgent care centres, minor injury units and emergency departments; all community and hospital paediatric clinical staff.

1. Introduction

1.1 Bruising is the commonest presenting feature of physical abuse in children. Serious case reviews and individual child protection cases across Cheshire 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 (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.

While this protocol by necessity focuses on children who are not independently mobile due to their age, the information in this protocol is also relevant to disabled children of all ages who are not independently mobile.

1.3 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

1.4 In light of the NICE guideline 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 the majority of children with bruising who are not independently mobile be referred to Children’s Social Care and for a Consultant Paediatric opinion. Professionals should always have a higher rate of suspicion when a child is not independently mobile and there is no explanation for the injury, or explanations change during interview. The protocol has been approved by the Pan Cheshire Policies and Procedures Group.

2. Definitions

2.1 **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.

2.2 **Bruising**: extravasation of blood in the soft tissues, producing a temporary, non-blanching discoloration 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 millimetres 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 [http://www.core-info.cardiff.ac.uk/reviews/bruising](http://www.core-info.cardiff.ac.uk/reviews/bruising)

3.2 Although bruising is not uncommon in older, mobile children, bruising in a baby who is not yet crawling and therefore has no independent mobility is very uncommon. Approximately 17% of infants who are cruising have bruises, while 52% - 87% of children who are walking have bruises. 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.

3.3 The head is by far the commonest site of bruising in child abuse. Other common sites in abuse include the ear, neck, trunk, buttocks, thighs and arms. Bruising patterns in disabled children showed that their lower legs, ears, neck, chin, anterior chest and genitalia were rarely bruised accidentally.

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.
3.6 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 professional or staff working with children 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, professionals are reminded that mobile children who are abused may also present with bruising (Baby Peter 2008, Daniel Pelka 2011, and Keanu Williams 2012). 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.

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 or staff member 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. Professionals should always have a higher rate of suspicion when a child is not independently mobile and there is no explanation for the injury or explanations change during interview. **In most instances it is expected that this will result in referral to Children's Social Care.**

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 community midwife. Where practitioners are uncertain whether bruising is the result of birth injury they should refer immediately to the Duty Consultant (or associate specialist) Paediatrician.

6.3 Where a decision to refer is made, it is the responsibility of the professional who first learned of or observed 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 7.1, for a medical opinion before reaching any conclusions on the case.

6.7 Referral should, in the first instance, be made by phone to the relevant Contact and Referral Team:

Cheshire West
During office hours (8.30am – 5.00pm, Mon – Thurs, 8.30am – 4.30pm, Fridays)
**Cheshire West and Chester:** 01606 275099
At all other times (including weekends and over Bank Holidays)
**Cheshire West and Chester Emergency Duty Team:** 01244 977277

Cheshire East
During office hours (8.30am – 5.00pm, Mon – Thurs, 8.30am – 4.30pm, Fridays)
**Cheshire East Consultation Service (ChECS) - 0300 123 5012**
At all other times (including weekends and over Bank Holidays)
**Cheshire East Emergency Duty Team:** 0300 123 5022

6.8 All telephone referrals must be followed up within 48 hours with a written referral, using the appropriate Multi-Agency Referral Form and must be fully documented in the patient records
[https://online.cheshirewestandchester.gov.uk/childsocialcarereferralform/default.aspx](https://online.cheshirewestandchester.gov.uk/childsocialcarereferralform/default.aspx)

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

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 Consultant Paediatrician on call to arrange 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 the appropriate hospital for your area:
Mid Cheshire Hospitals NHS Foundation Trust – Leighton Hospital Site:
During normal working hours bleep the Consultant Community Paediatrician on call via switchboard - Tel: 01270 255 141
Out of hours bleep the Consultant Paediatrician (hospital) on call via the switchboard - Tel: 01270 255 141

Macclesfield Hospital Safeguarding Children Team:
Tel: 01625 661770
Consultant Paediatrician on call – Macclesfield District General Hospital
(For Macclesfield, Holmes Chapel, Congleton, Poynton areas) on 01625 421000

Countess of Chester Hospital NHS Foundation Trust:
Contact the Consultant Paediatrician on call via switchboard - Tel: 01244 365000

7.3 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

7.4 The Consultant Paediatrician / Consultant Community Paediatrician must liaise with Children's Social Care as soon as possible with regard to the outcome of the assessment following its completion.

7.5 Where a referral is delayed for any reason, or where bruising is no longer visible, a Consultant Paediatrician / Consultant Community 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.

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. (See the ‘Information for parents and carers’ leaflet).

8.3 If a parent or carer is uncooperative or refuses to take the child for further assessment or investigation, this should be reported immediately to Children's Social Care. If possible the child should be 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 local acute or community paediatric department 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 the Safeguarding Lead for the agency who has first observed the bruise or in the absence of such, 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 discuss the findings with the child’s health visitor and vice versa. Advice can be sought from the Named GP Safeguarding Children but if unavailable, should not delay referral.

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 Health staff should seek advice or discuss the case with their Safeguarding Children Team but if unavailable, should not delay referral. In these circumstances the Safeguarding Children Team should be notified as soon as possible following referral.

10.6 An individual practitioner / staff member 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. If you remain unhappy about the outcome of any discussion remember to use the Escalation Policy.

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: advice for practitioners providing safeguarding services 2015). “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. **History Taking and Examination**

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 by the Consultant Paediatrician / Community Paediatrician. 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 identify 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 on a body diagram (Appendix A), and a careful record of the carers/parents description of events and explanation for the bruising made in the clinical notes. GP records should be flagged as “at risk”. If a child safeguarding medical examination takes place under child protection procedures the relevant hospital documentation must be completed.

11.8 The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be over-emphasised.

11.9 See Appendix B for the pathway for the assessment, management and referral of actual or suspected bruising.

12. Assessing the Significance of Bruising

12.1 Bruising is the commonest presenting feature of physical abuse in children. The younger the child the greater the risk that bruising is non-accidental.

The following features indicate an increased risk that bruising is due to abuse rather than to accidental or medical reasons. Consideration should be given to the degree, if any, to which these features are present taking into account the age and ability of the child:

- Bruising on the head especially the face, ears and neck
- Multiple bruising especially of uniform shape or symmetrical positions
- Bruises in clusters
- Large bruises
- Bruising on soft tissues (away from bony prominences) especially cheeks and around eyes
- Bruising on the abdomen, upper limbs (especially arms and hands), buttocks and back
- Bruising around the anus or genitals
- Imprints and patterns including fingertip bruising, hands, rods, ropes, ligatures, belts and buckles
- In some areas of the body, such as the cleft of the buttocks and the ears, bruising caused by an object or implement may not always show a typical imprint of the injuring object.
- Petechiae
- A boggy forehead swelling with peri-orbital oedema (caused by violent pulling of the child's hair)
- Accompanying injuries such as scars, scratches, abrasions, burns or scalds
- Bruising in disabled children

12.3 Features of innocent bruising:

- In mobile children, the commonest sites of bruising are the shins and the knees
- Bruising as a result of trips and falls is commonest on the back of the head, the front of the face, including the forehead, the nose, upper lip and chin
- Children who are pulling to stand may bump their head sustaining bruising to the forehead

However, these features may also occur in abused children and it is important to re-emphasise that any bruising in a not independently mobile child is unusual.

13. Other Sources of Guidance and Information

Continuum of Need and Response, Cheshire West and Chester Local Safeguarding Children Board
http://cheshirewestlscb.org.uk/professionals/continuum-of-need/

Continuum of Need and Response, Cheshire East Local Safeguarding Children Board

Working Together to Safeguard Children, HM Government, 2015

What to do if you’re worried a child is being abused: advice for practitioners, HM Government, 2015

Child Protection Companion, Royal College of Paediatrics & Child Health

When to Suspect Child Maltreatment (NICE Clinical Guideline 89)
https://www.nice.org.uk/guidance/cg89

GMC – Protecting children and young people – The responsibilities of all doctors

_We would like to express our thanks to the NHS Hampshire Named Doctor and_
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Appendix A

Skin Map

Child’s name:

Date of birth:

Date/time of skin markings/injuries observed:

Injuries first observed by:

Information recorded by: Date: Time:

Name: Signature:
Pathway for the assessment, management and referral of actual or suspected bruising

Health Practitioner observes or is made aware of bruise or suspicious mark

SUSPECT child maltreatment¹

Seek an explanation, examine and record accurately

Note any other features of abuse² e.g. bruises on face and ‘soft’ areas, bruises in clusters or imprints

Explain to family the reason for immediate referral to Children’s Social Care and On call Consultant Paediatrician / Community Paediatrician

Immediate Phone Referral to Children’s Social Care for multi-agency assessment and information sharing

Inform GP, Health Visitor and Children’s Safeguarding Team

Immediate Phone Referral to On call Consultant Paediatrician / Community Paediatrician and child seen urgently for further investigation to exclude a medical condition

Inform GP, Health Visitor and Safeguarding Children Team

Follow

http://www.proceduresonline.com/pancheshire/

¹ NICE clinical guideline 89: When to suspect child maltreatment, July 2009
(SUSPECT means serious level of concern about the possibility of child maltreatment but not proof of it)