

Protocol for the assessment of Bruising in Non-Mobile Children

Bruising in non-mobile children is rare and therefore there is a significant risk that bruising may indicate abusive or neglectful care. Unfortunately, nationally and locally bruising is not always responded to appropriately by Health Visitors, Doctors, GPs and other health professionals. As a result a significant number of abusive events have been missed resulting in children being placed at risk, resulting in serious untoward incidents and serious case reviews.

The above protocol sets out to address this by requiring all professionals to refer bruising in non- mobile children for assessment by a Consultant Paediatrician and Social Care.

Non-mobile children are defined as not yet rolling, crawling, cruising or walking independently or are older children who are not mobile because of a disability. Practitioners should include all children under 6 months.



Any other injuries or unexplained bruising follow Safeguarding Procedures and seek advice from Safeguarding Supervisor.

Unfortunately issues around birth marks including **Mongolian Blue spots** have led to a small number of families being inappropriately referred causing significant distress. Such birth marks are sometimes not being recognised and are not documented in the child's records when first seen.

It is therefore essential to learn how to recognise birth marks in small infants and to document them in the CHILD'S HEALTH RECORDS, including the PARENT HAND HELD RECORD. New guidelines and processes are being devised to support this in Maternity practice and during "baby checks" in the community. All birth marks and any other marks/ injuries noted prior to discharge from hospital should be recorded. **A body map should be completed within the parent handheld record and in the child's health record.** When there are no visible marks the records should reflect this.

Hopefully this will reduce the incidence of confusion and it makes it even more important that new bruising in non-mobile children is referred for expert assessment.



What are Mongolian Spots?

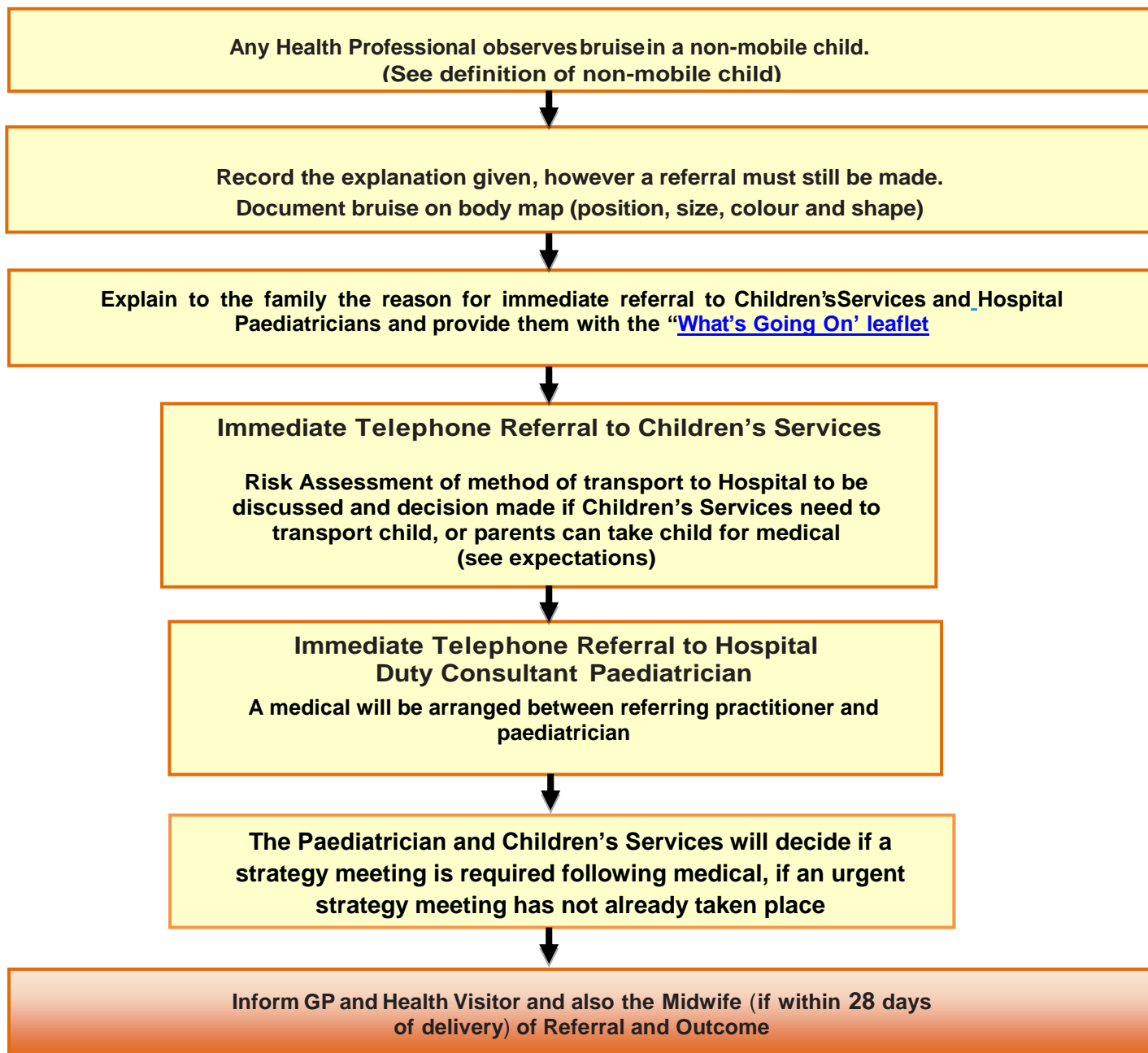
- Hyperpigmented skin areas
- Usually seen at birth or early life
- Often familial
- Common in children of Asian / African descent
- Rarer in Caucasians
- Usually bluish / slate-grey in colour
- Usually flat and not raised, swollen or inflamed
- Usually round / ovoid but can be triangular, heart- shaped or linear
- Can be single or multiple marks
- Usually on the lower back / sacrum / buttocks
- Trunk, extremities (rarer)
- Face or scalp (extremely rare)

Differentiating Mongolian Spots from Bruising:

- Typical sites
- **Non-tender**
- Usually homogeneous in colour
- Don't change colour and take months / years to disappear
- Must always document presence of Mongolian spots, including how extensive, site and shape.

(refer to photographs for examples)

Protocol for the assessment of bruising in “Non-Mobile” Children



For Children's Services phone:

DURHAM
First Contact
24 Hour line
03000 267979

DARLINGTON
Children's Front Door
During office hours
01325 406252

DARLINGTON
Emergency Duty Team
Out of Office Hours
01642 524552

To contact a Paediatrician:

Please call the appropriate switchboard and ask to speak to the on-call Paediatrician.

DURHAM
University Hospital
North Durham
0191 333 2333

DARLINGTON
Darlington Memorial
Hospital
01325 380 100

References:

NICE clinical guidelines 89: When to suspect child mistreatment – July 2009:
<https://www.nice.org.uk/guidance/cg89>

Durham Royal College of Paediatrics and Child Health (2013), Child Protection Companion 2013 – 2nd Edition:
<https://www.rcpch.ac.uk/key-topics/child-protection>

Further information:

Durham Safeguarding children Partnership:
www.durham-scp.org.uk

Durham First Contact email:
E: FirstContact@durham.gov.uk

Darlington Safeguarding Partnership:
www.darlington-safeguarding-partnership.co.uk

Darlington Children's Initial Advice Team (CIAT) email:
E: childrensfrontdoor@darlington.gov.uk

Royal College of Paediatrics and Child Health – Child Protection Evidence – Bruising:
<https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising>

National Institute for Health and Care Excellence (NICE) – Child Maltreatment – When to suspect maltreatment in under 18's:
<https://www.nice.org.uk/guidance/cg89>

British Medical Journals – Patterns of bruising in preschool children:
<https://adc.bmj.com/content/100/5/426>

Nottingham video on Bruising in non-mobile babies for professionals
'Babies that don't cruise, don't bruise'
You tube video: <https://youtu.be/dSGgpFdvWpA>

Information for Parents and carers:

['What's going on' Leaflet](#) about bruising in non-mobile children:

MANAGING BRUISES IN NON-MOBILE BABIES AND NON-MOBILE CHILDREN

Roles and Responsibilities

This guide should be used in conjunction with the DSCP safeguarding practice guidance.

LEAFLET FOR PARENTS: <https://www.durham-scp.org.uk/wp-content/uploads/2018/12/Brusing-A4-folded-to-1-3-A4-information-for-parents-and-carers-V3.pdf>

If the child, siblings or anyone else is in immediate danger, contact the police on 999

Non-mobile children are defined as not yet rolling, crawling, cruising or walking independently or are older children who are not mobile because of a disability. RCPCH (2013). Practitioner should include all children less than 6 months.

Information gathering, while important, should not delay medical assessment or referral to the safeguarding hub.

ROLE	RESPONSIBILITY
Professional who is informed of the bruise by a parent or carer but has not seen it (for example; telephone triage)	<p>When abuse is suspected in a seriously ill or injured child, that child should be referred immediately to hospital and transported by ambulance. A referral should be made as soon as possible to Children’s Services.</p> <ul style="list-style-type: none"> • Explain, to the parent/carer, the Durham procedure for bruising in non-mobile children and that a referral will be made to the Local Authority if there is a bruise when the child is seen, regardless of whether or not the explanation appears reasonable and a Paediatrician will be asked to complete a full assessment. • Document explanation given for the bruise • Make arrangements via telephone with parent/carer to visualise the bruise for assessment the same day • Document findings from assessment and follow procedural flowchart appropriately
Community health professional (for example; Health Visitor,	<p>Any bruising in a non-mobile child should raise suspicion of maltreatment and must result in an immediate referral to Children’s Services and on call paediatrician. This referral is the responsibility of any professional who has observed or been made aware of a bruise on a non-mobile child. A discussion should be held between the professional concerned and Children’s Services as to the safe transport and escort of the child to hospital.</p>

<p>Early Years worker ,GP, Community Midwife, Community Paediatrician, pharmacist) who sees the bruise</p>	<ul style="list-style-type: none"> • Check parents hand held record for any bruising recorded at birth. • Clarify if there is a history of trauma (will need to be seen in ED in the first instance) or not (will need to be seen by the Consultant Paediatrician). Document any explanation given by the parent/carer • Explain (to the parent/carer) the Durham protocol for bruises in non-mobile children and that a referral will be made to First Contact if there is a bruise when the child is seen, regardless of whether or not the explanation appears reasonable and a Paediatrician will be asked to complete a full assessment. Give ‘What’s Going On’ leaflet (see link above) • Identify any siblings (including those living elsewhere) – names, dates of birth, current location. • Record the identity of all members of the household and non-resident parents • Before leaving/letting child or child leave (unless urgent transfer to ED), make a verbal referral to First Contact. Agree a plan with the Social Worker regarding transport of the child to hospital. Remember to share details of siblings. • The referrer must check that the baby has presented at hospital within 2 hours of the agreed time. Referrer must inform the parents that if they do not attend hospital within given timescale Police and Social Worker will attend the family home to escort to hospital. • Contact the Consultant Paediatrician to share clinical information as appropriate and arrange a medical. • Complete First Contact referral to confirm verbal referral as soon as possible to ensure full information available, but certainly within 24 hours to add to child’s record. • Advise Safeguarding Children team of referral.
<p>Emergency Department Team</p>	<p>An urgent safeguarding medical must be undertaken by a Consultant Paediatrician.</p> <ul style="list-style-type: none"> • Assess child for trauma and treat as appropriate. Ensure non mobile child is fully undressed for examination and document/ body map any bruises. • Apply CWILTED assessment tool • Record any explanation given by parent/carer • Explain (to the parent/carer) the Durham protocol for bruises in non-mobile children and that a referral will be made to First Contact if there is a bruise when any child is seen, regardless of whether or not the explanation appears reasonable and a Paediatrician will be asked to complete a full assessment. Check that parents have received the leaflet on Bruising in non-mobile children and if not give

	<p>parents leaflet.</p> <ul style="list-style-type: none"> • Contact First Contact/EDT and make an urgent verbal referral. Contact the on-call Consultant Paediatrician in the first instance, although SW Team Manager /EDT will always need to liaise with Consultant Paediatrician regarding arrangements for Paediatric assessment/Child Protection Medical/Strategy. • Document clearly in records all actions and site of bruising.
<p>Consultant Paediatrician</p>	<p>Following this medical if there are safeguarding concerns the paediatrician will contact Children’s Services.</p> <ul style="list-style-type: none"> • Liaise with First Contact/Safeguarding MASH/Social Worker to support their decision making regarding next steps; this will normally be as part of an initial strategy discussion involving the police or full multi agency strategy meeting • Ascertain contact/supervision arrangements for parents/carers • Complete Paediatric Assessment /Child Protection Medical(s) and participate in strategy discussion • Provide written medical report and include body map
<p>Children’s services / Multi-agency Safeguarding Hub / Emergency Duty Team</p>	<p>It is the responsibility of Children’s Services and the Paediatrician to decide, through consultation if bruising is consistent with an innocent cause or not and whether the social worker is required to attend to convene a strategy.</p> <ul style="list-style-type: none"> • To check Children’s Services records and share any information that would be relevant to assist the health staff in assessing child protection concerns. Children’s services will aid the practitioner in determining if the vulnerabilities are so significant a SW will need to attend or if they agree parents should take child to attend A & E for paediatric view within a timescale. • To assist in identifying siblings if the child is known on the system. • Following outcome of paediatric view and indicator that bruise is a result of a non - accidental injury a case file will be opened to progress to a Statutory Children’s team and a Strategy will be held including Paediatrician and Police attendance to determine if a S47 enquiry is required and if this will be either single agency or a joint investigation. • If a paediatric view is inconclusive and there is no non - accidental injury, discussion will take place between First Contact or EDT (on unopened/closed cases), or Children’s Services team if an open case, with health staff to ensure that the process has been followed. The team will ascertain there are no further risk vulnerabilities linked to neglect, lack of supervision prior to the Contact being closed. This will include the confirmation of the child has been assessed by a Consultant Paediatrician, and noting that a bruise in a non-mobile child has been explored and no evidence that the bruise is non - accidental in nature and meets the threshold for Child protection

procedures to be instigated.

- When instances occur outside of working week hours, and where the child is well and there are no siblings that could be at risk, Emergency Duty Team Social Worker will discuss with On-Call Consultant Paediatrician and police to decide if an urgent assessment and strategy is required or if it is safe for child to be admitted overnight for further actions to take place “in hours”.
- Where there are siblings that could be at risk to agree how their safety will be assured. This may take the format of an initial safety plan/ or strategy discussion with a further strategy, meeting planned for the following day.
- The Emergency Duty Team will progress the referral to the statutory area children’s Families First team who will arrange a strategy meeting in which the Consultant Paediatrician will be a participant, along with a safeguarding Health lead. The strategy will determine if a further in-depth Child Protection medical is required including siblings dependent upon the concerns presented.