Children's MARS Multi-Agency Protocol

The Assessment of Injuries to Babies and Children

This protocol has particular reference to the assessment and management of injuries to **non-mobile babies** and **children who are not independently mobile**.

March 2021

Contents

Introduction and principles

This protocol is set within the context of the One Family Approach - Helping Children and Families in North Lincolnshire document 2020/24 which sets out how services support children, young people and their families and how we work together to provide integrated services. Our One Family Approach aims for children to be in their family, in their school and in their community.

The protocol is relevant to practitioners working within North Lincolnshire who may come into contact with babies and children, particularly those who are not independently mobile, and who may be in a position to identify that such a baby or child has received an actual or suspected bruise, burn or scald.

A key finding from recent research is:
Bruising was the most common injury in children who have been abused. It is also a common injury in non-abused children, the exception to this being pre-mobile infants where accidental bruising is rare (0-1.3%). The number of bruises a child sustains through normal activity increases as they get older and their level of independent mobility increases.
See Child Protection Evidence: Systematic review on Bruising (RCPCH) 2020

A bruise or an injury must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. Any bruising, or mark on the skin that might look like bruising, in a child of any age or where a child is not independently mobile, that is observed by or brought to the attention of any practitioner must be considered as a matter of concern and thoroughly explored.

It should be noted that other unusual marks on the skin or unusual sites of bleeding (e.g. bleeding from the mouth in young children) without a clear explanation may also be a sign of non-accidental injury and should also be considered in line with this protocol.

It is recognised that a small percentage of bruising in non-independently mobile babies and children will have an innocent explanation (including medical causes). However, practitioners should not make decisions in isolation due to the difficulty in excluding non-accidental injury.

Practitioners are reminded that all children are vulnerable to harm and as such practitioners should remain alert to signs of abuse, unexplained or unusual injuries or injuries where the explanation provided is not congruent with the injury sustained.

Definitions

In order to ensure a consistent approach to consideration, the definition of a number of frequently used terms is provided:

Child
Anyone who has not yet reached their 18th birthday. ‘Children’ therefore means ‘children and young people’ throughout.

Baby
For the purpose of this guidance, a baby is defined as a child who has not yet reached their 1st birthday.

Non-mobile baby
- babies who are not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently
- all children under the age of 6 months

Some babies can roll from a very early age and this does not constitute self-mobility.

Not independently mobile
- all babies and children who require any assistance to move
- all non-mobile babies

An older infant or child with a disability with any of the risk indicators would also warrant careful consideration.

Bruise/Bruising
Bruising is caused by leakage of blood into the surrounding soft tissues, producing a temporary 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.

Petechiae
Red or purple spots, less than two millimetres in diameter and often presenting in clusters.

Subconjunctival haemorrhage
Bleeding within the whites of the eyes and should be considered as similar to bruising to the eye itself for the purposes of this protocol.

Burn
Damage to the skin or other body parts caused by extreme heat, flame, contact with heated objects, or chemicals. Burn depth is generally categorised as first, second, or third degree.

Scald
Tissue damage caused by applied wet heat such as hot water or steam.

Fracture
A medical condition in which there is a break in the continuity of the bone. This may be as a result of high impact force or stress or a minimal trauma injury as a result of certain medical conditions that weaken the bones.

Non-accidental injury
Damage, e.g. bruise, burn, scald, fracture, deliberately inflicted (whether intentionally or unintentionally).

Unexplained injury
An injury, the cause of which, has not yet been determined or ascertained. It is anticipated that this term may be used in **early consideration** of injuries but could continue to be used where there is an unsuitable explanation.

Unsuitable explanation
An explanation for an injury or presentation that is implausible, inadequate or inconsistent:

- with the child's
    - presentation
    - normal activities
    - existing medical condition
    - age or developmental stage
    - account compared to that given by parent and carers
- between parents or carers
- between accounts over time

An explanation based on cultural practice is also unsuitable because this should not justify hurting a child.

Further terms can be found defined along with synonyms in Appendix 1.

Specific considerations

Bruising in children of any age

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 practitioner must be considered as a matter of concern and thoroughly explored. Practitioners must be 'professionally curious' to determine further information in the interests of the child. It is essential that professionals exercise professional curiosity at all times as it is likely that signs of any form of abuse will be identified when dealing with an un-associated incident. A satisfactory explanation should be sought and the characteristics of the bruising should be assessed and the distribution carefully recorded. The bruising should be assessed in the context of personal, family and environmental history to ensure that it is consistent with an innocent explanation.

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

'Rough handling' and 'behavioural management' are never acceptable reasons for an injury and must not be accepted as a 'reasonable explanation'.

For non-mobile babies

Bruising

Bruising to very young babies may be caused by medical issues e.g. birth trauma, however this is rare. In addition, some medical conditions can cause marks to the skin in very young babies that may resemble a bruise. 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. The younger the child the greater the risk that bruising is non-accidental

and the greater potential risk. In all cases, unless the specific mark that has been identified and confirmed as arising from a medical condition, this protocol should be followed to enable multi-agency assessment of the suspected bruise.

Birth injury
Both normal births and instrumental delivery may lead to development of bruising and of minor bleeding into the eye. However, practitioners should be alert to the possibility of physical abuse and follow this policy if there is any doubt about the features seen. Any bruising or bleeding into the eye during birth must be documented in professional records, to allow for comparative assessment.

Birthmarks
Birthmarks may be present at birth and can also appear in the early weeks and months. Certain birthmarks, particularly Mongolian Blue Spots can mimic bruising. Birthmarks, in particular Mongolian Blue Spots, must be documented in professional records.

Self-inflicted injury
It is rare for a non-mobile infant to cause any significant self-inflicted injury during normal activity.

Injury from other children
Explanations that a sibling has caused the injury should still be further explored which must include a detailed history of the circumstances of the injury and consideration of the parent's or carer's ability to supervise the children.

Subconjunctival haemorrhage
Any baby who develops a subconjunctival haemorrhage which is not birth related, or where there is no obvious other cause, should be assessed by a paediatrician.

For children who are not independently mobile
Immobility in older children should be taken into account as a risk factor, for example in disabled or very sick children.

Actions to be taken

As far as possible, parents or carers should be included in the decision-making process, unless to do so would jeopardise information gathering (e.g. information or evidence could be destroyed) or if it would place the child at risk.

Where safe to do so, whenever a practitioner identifies a child with an injury, the practitioner should seek an explanation from the parent or carer, and where possible, from the child themselves. All people who live within the family home, including siblings and partners/significant others (such as aunts and uncles, grandparents, etc.) who do not live there but participate in any aspect of the child's care, should be considered. See the section on 'Informing parents/carers and obtaining consent' below.

This protocol requires any practitioner who identifies an actual or suspected injury to a baby or child who is non-mobile, or suspects that an injury to a child is non-accidental as a result of abuse or neglect to make a referral to Children's Services Single Point of Contact.

North Lincolnshire Children's Services Single Point of Contact can be contacted on 01724 296500 or out of office hours on 01724 296555.

Where a practitioner identifies an actual or suspected injury to a baby or child who is non-mobile, they must discuss the injury and explanation with a supervisor, named or designated safeguarding lead, either within their own service/agency or with a partner agency. The identifying practitioner, and/or the supervisor, should consider seeking advice from a qualified health professional if further support is required. No practitioner should make the decision alone that the explanation offered by parents/carers, explains the injuries sustained by a non-mobile baby/child. However, in the absence of not having another person to discuss the injury with, the practitioner should not delay a discussion with, and any subsequent referral being made to Children's Services. This discussion and any referral are the responsibility of the first practitioner to be made aware of or observe the injury.

Where possible the identifying practitioner suspecting a non-accidental injury to a mobile child should discuss the injury and explanation with a supervisor, named or designated safeguarding lead, either within their own service/agency or with a partner agency. The identifying practitioner should consider seeking advice from a qualified health professional if further support is required. However, in the absence of not having another person to discuss the injury with, the practitioner should not delay a discussion with, and any subsequent referral being made to Children's Services, if based on their own professional judgement this needs to be made immediately. Any referral is the responsibility of the first practitioner to be made aware of or observe the injury.

If a practitioner has concerns about a child's welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant harm, then they should share the information with or make a referral to Children's Services.

If any practitioner believes that the child is at immediate risk of significant harm, they should contact the police as the only service who can immediately safeguard the child.

If the child appears ill or seriously injured the practitioner should seek or facilitate emergency treatment and notify Children's Services and/or the police of their concerns.

In all cases, contemporaneous, comprehensive, accurate, dated, timed records should be kept. Mapping, description and recording of the size, colour, characteristics of injuries, including site, pattern and number of bruises should be made on a body diagram. A careful record of what was seen should be made using a body map or line drawing if appropriate (see Appendix 2). A careful record of parents and carers description of events and explanation for the injury should be made in the notes.

A process flowchart can be found in Appendix 3.

Informing parents/carers and obtaining consent

It would be expected that in most cases the practitioner will inform the parent/carer of their intention to make a referral and obtain their consent. However, in deciding whether or not to inform the parent/carer that a referral is to be made or obtain their consent, the practitioner who has identified the suspected injury must consider the possibility that to do so may place the child at risk. In this instance the practitioner does not need to obtain consent to make a referral. If the parent or carer is uncooperative or refuses to take the child for further assessment, if this is required, this should be reported to Children's Services Single Point of Contact.

If the practitioner concludes that informing the parent/carer or seeking their consent may place the child at risk, they should consult with Children's Services Single Point of Contact or the child's allocated Social Worker to obtain advice before speaking to the parent/carer.

In all cases, Children's Services Single Point of Contact must be advised if the parents or carers are aware of the referral and whether consent has been sought and the outcome of this.

Further detail in relation to information sharing and consent can be found in the Children's MARS Policy and Procedures for Assessing Need and Providing Help and in the Information sharing guidance on the Children's MARS website.

Action to be taken by Children's Services

The action following a referral, during normal working hours or out of hours, to Children's Services will be in line with the Children's MARS Policy and Procedures for Assessing Need and Providing Help.

Feedback will be given by Children's Services to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold and offer suggestions for other sources of more suitable support.

Medical assessment

Where the child appears in urgent need of medical attention (e.g. suspected fractures, bleeding, loss of consciousness), they should be taken to the nearest accident and emergency department via ambulance if necessary.

Where an injury is identified by paediatric/hospital staff, they will follow the principles contained with this protocol, and where necessary refer the matter to Children's Services in accordance with the Children's MARS Policy and Procedures for Assessing Need and Providing Help.

Should a decision be made that a medical assessment of a child be required see Appendix 4.

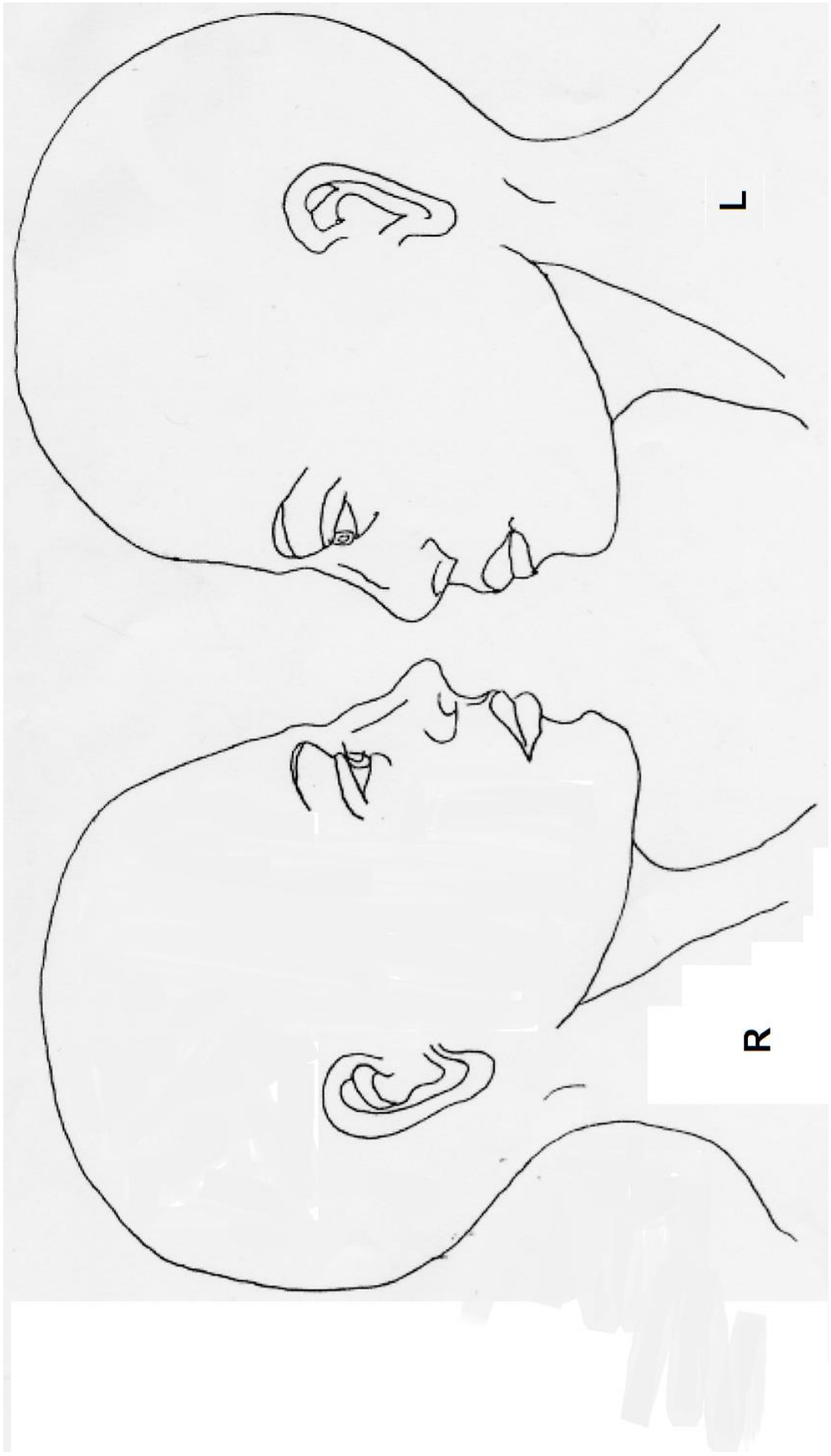
Differences of opinion

Where there are professional differences of opinion about actions taken, or decisions made, in respect of arrangements for helping or protecting children The Children's MARS Policy and Procedure for Escalation and Resolution should be followed.

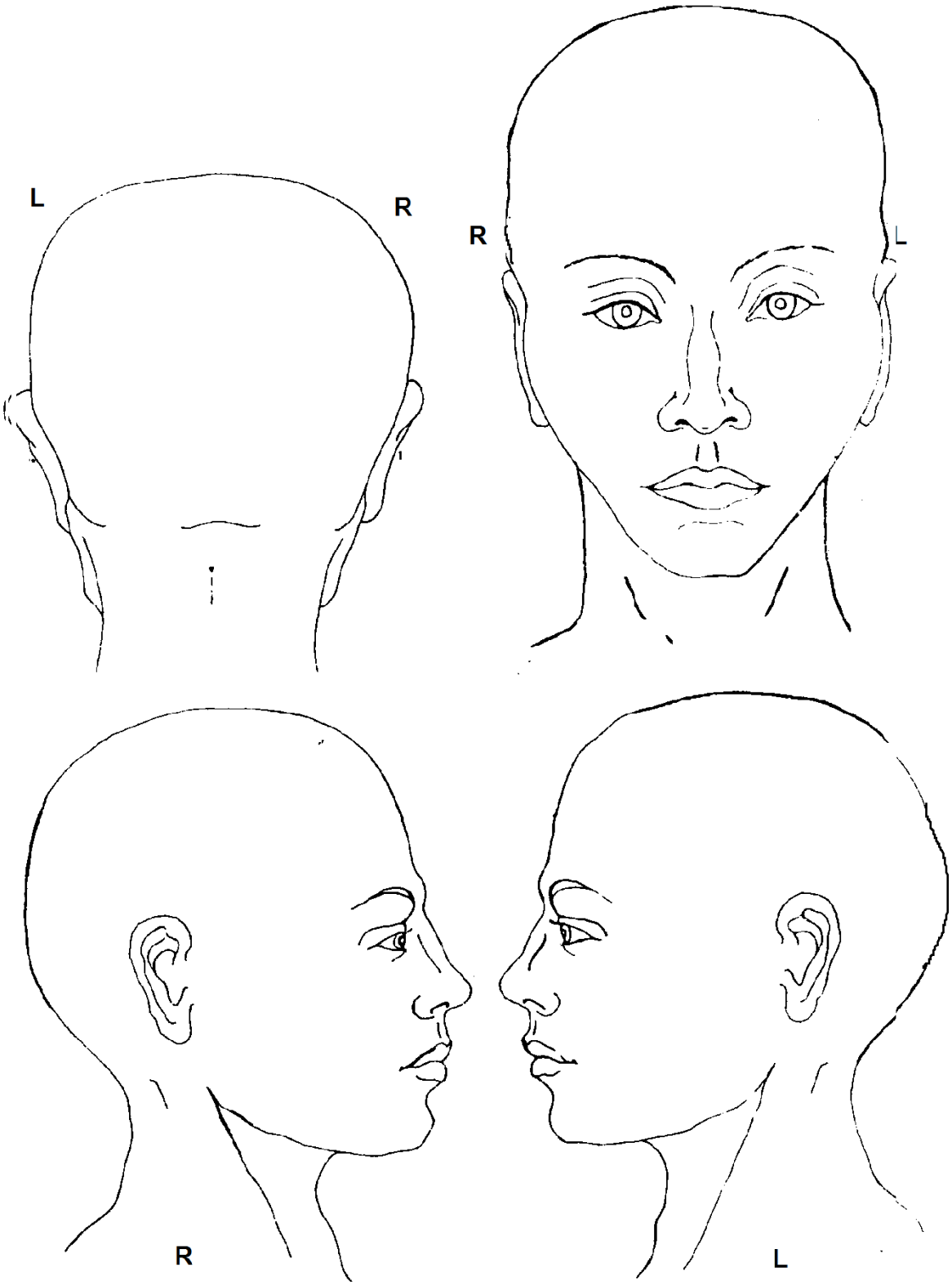
Appendix 1: Glossary

	Definition	**Synonyms** The terms in **bold** are frequently used as alternatives to the defined word
abrasion	An area damaged by scraping or wearing away.	**graze**, scrape, scratch, cut, gash, laceration, injury, contusion
bruise	An injury appearing as an area of discoloured skin on the body, caused by a blow or impact rupturing underlying blood vessels.	**contusion**, lesion, mark, injury, skin discoloration
contusion	A region of injured tissue or skin in which blood capillaries have been ruptured; a bruise.	**bruise**, lesion, mark, injury,, skin discoloration,
cut	A long, narrow incision in the skin made by something sharp.	**gash**, slash, **laceration**, **incision**, **wound**, injury
gash	A long, deep cut or wound.	**laceration**, **cut,** puncture, incision,
graze	A slight injury where the skin is scraped.	**scratch**, scrape, **abrasion**, cut, injury, sore
injury	An instance of being injured.	wound, bruise, cut, gash, scratch, graze, laceration, abrasion, contusion, lesion, sore
laceration	A deep cut or tear in skin or flesh.	**gash**, **cut**, **wound**, injury, tear, slash, mutilation, scratch, scrape, abrasion, graze, incision,
lesion	A region in an organ or tissue which has suffered damage through injury or disease, such as a wound, ulcer, abscess, or tumour.	**wound**, injury, bruise, abrasion, contusion, scratch, scrape, cut, gash, laceration,
scratch	A mark or wound made by scratching.	**graze**, scrape, **abrasion**, cut, laceration, wound
sore	A raw or painful place on the body.	inflammation, swelling, lesion
wound	An injury to living tissue caused by a cut, blow, or other impact, typically one in which the skin is cut or broken.	injury, lesion, cut, gash, laceration, tear, rent, puncture, slash

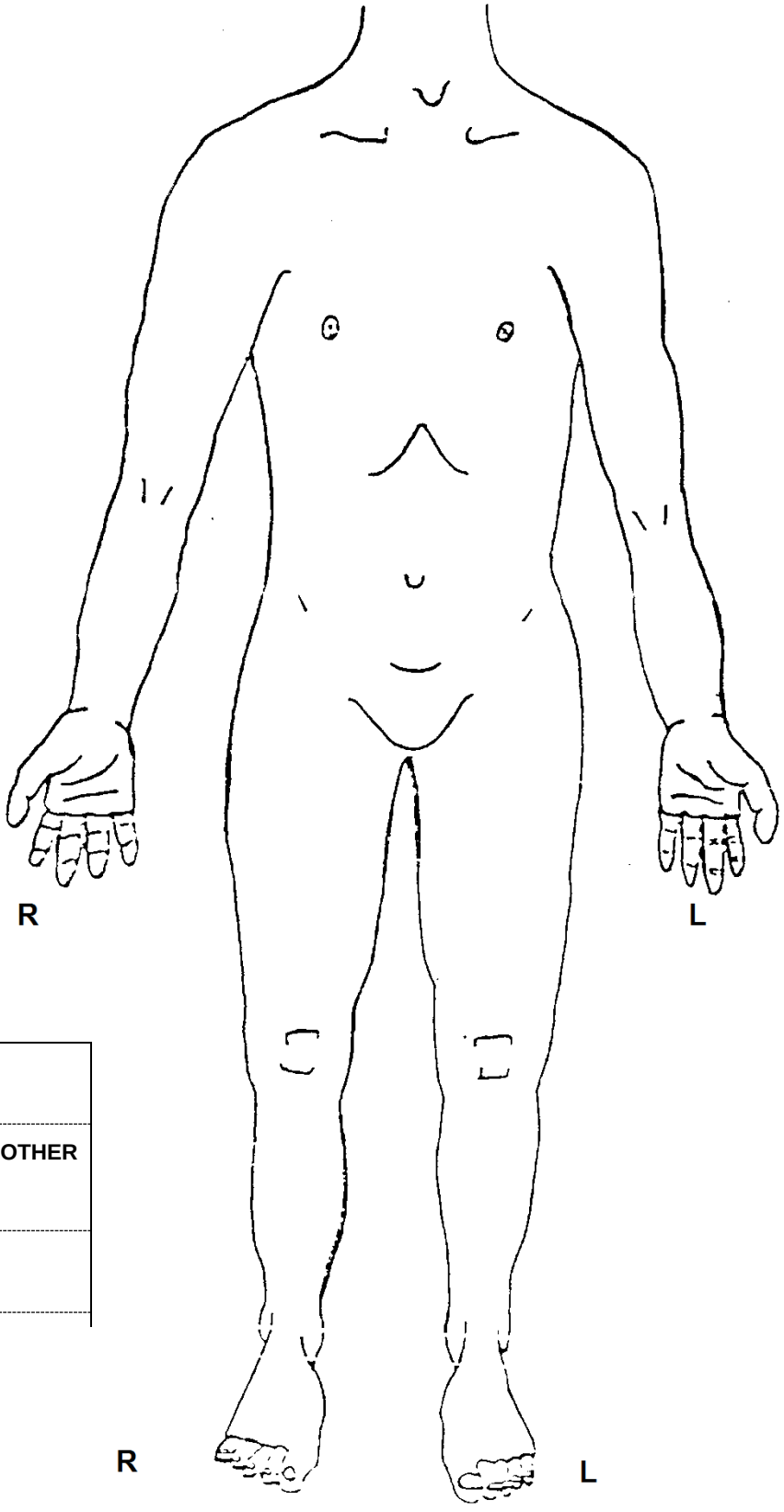
Appendix 2: Body maps



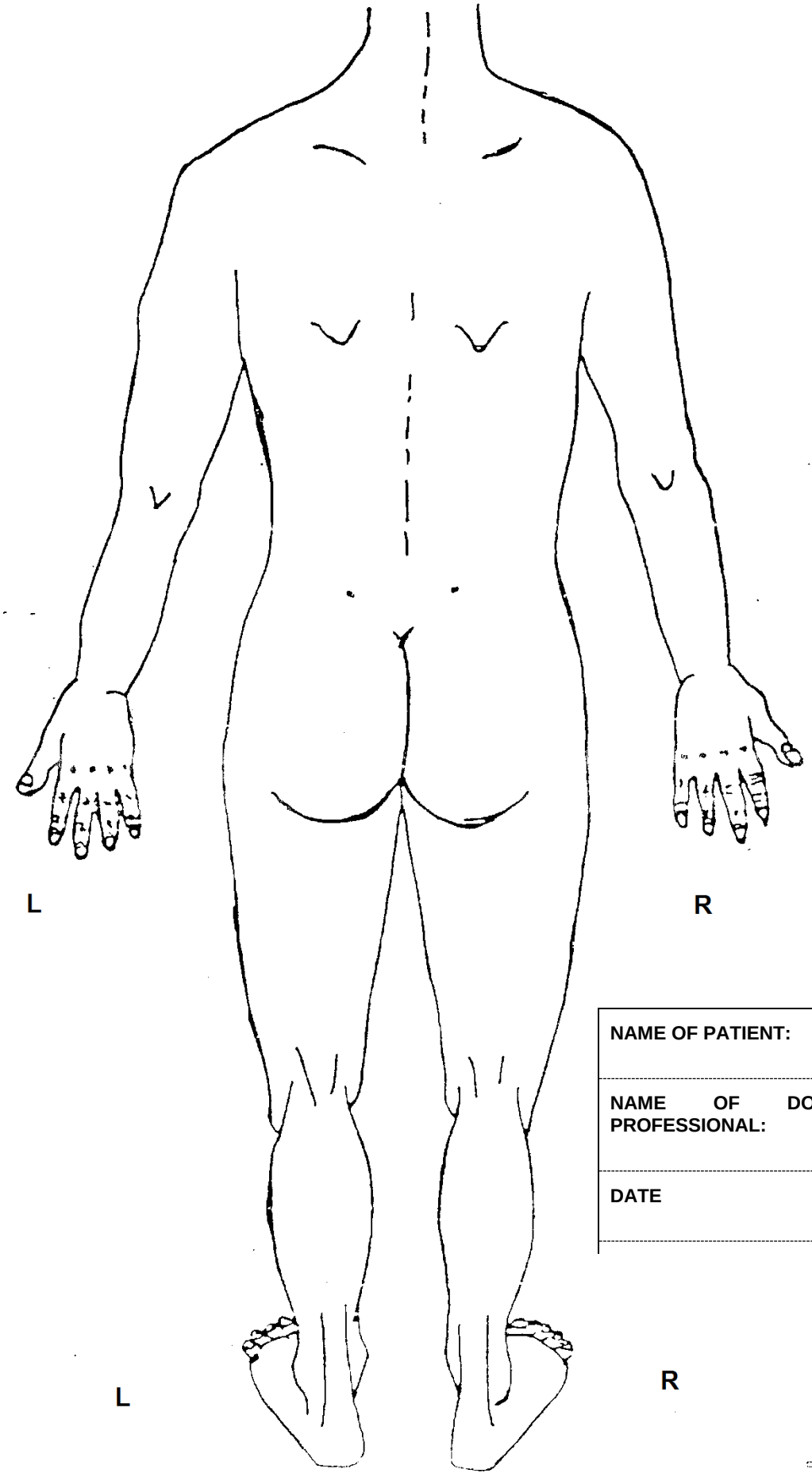
NAME OF PATIENT:	
NAME OF DOCTOR/ OTHER PROFESSIONAL:	
DATE	



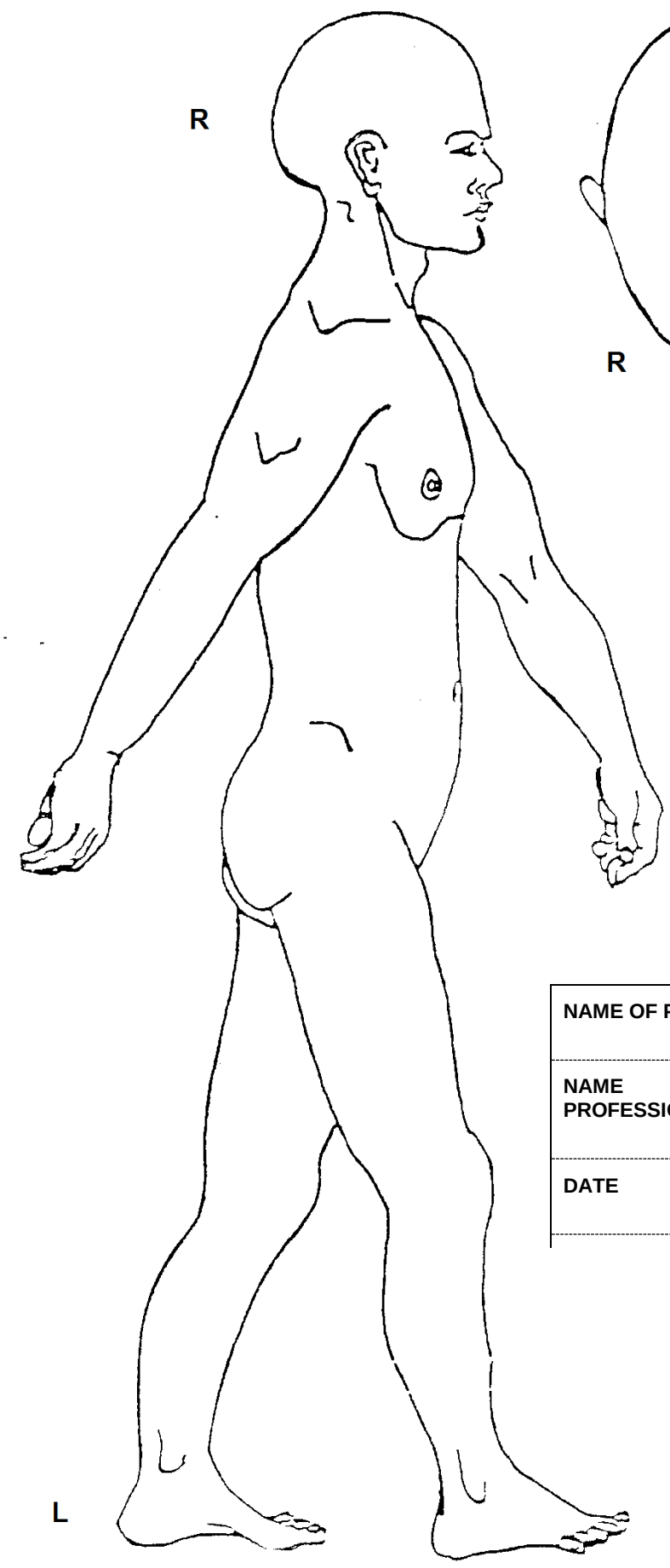
NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



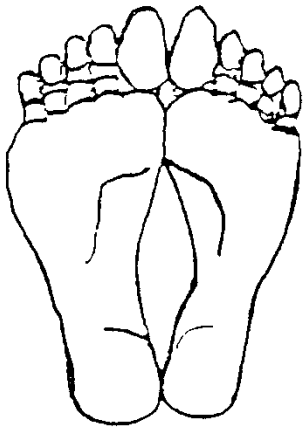
NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



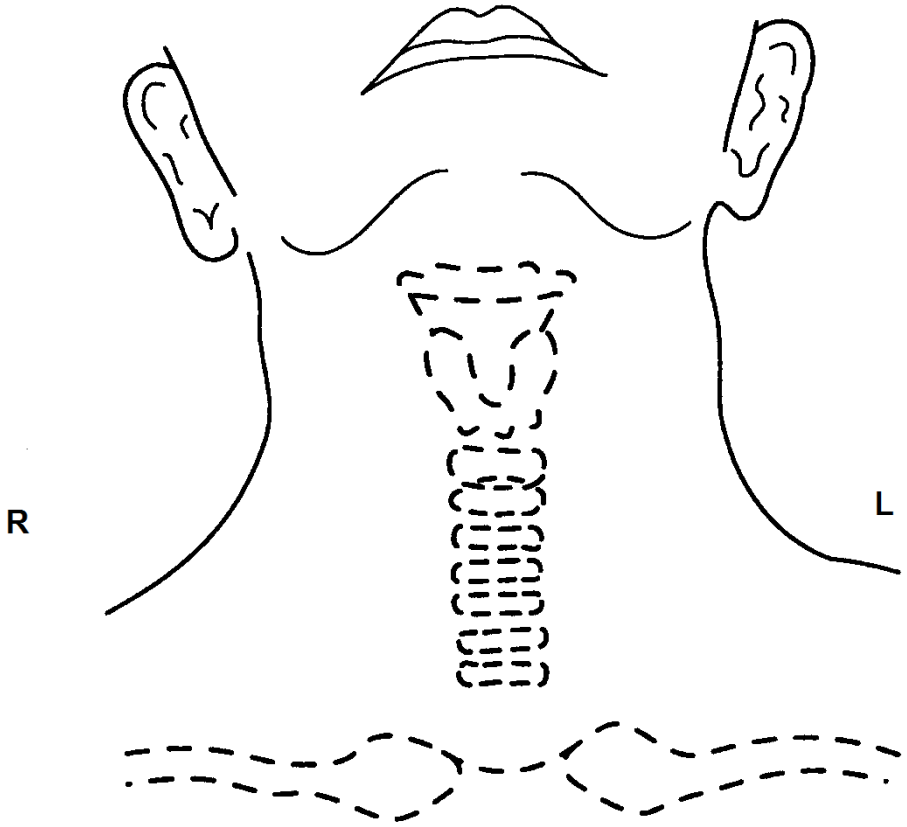
R L

L

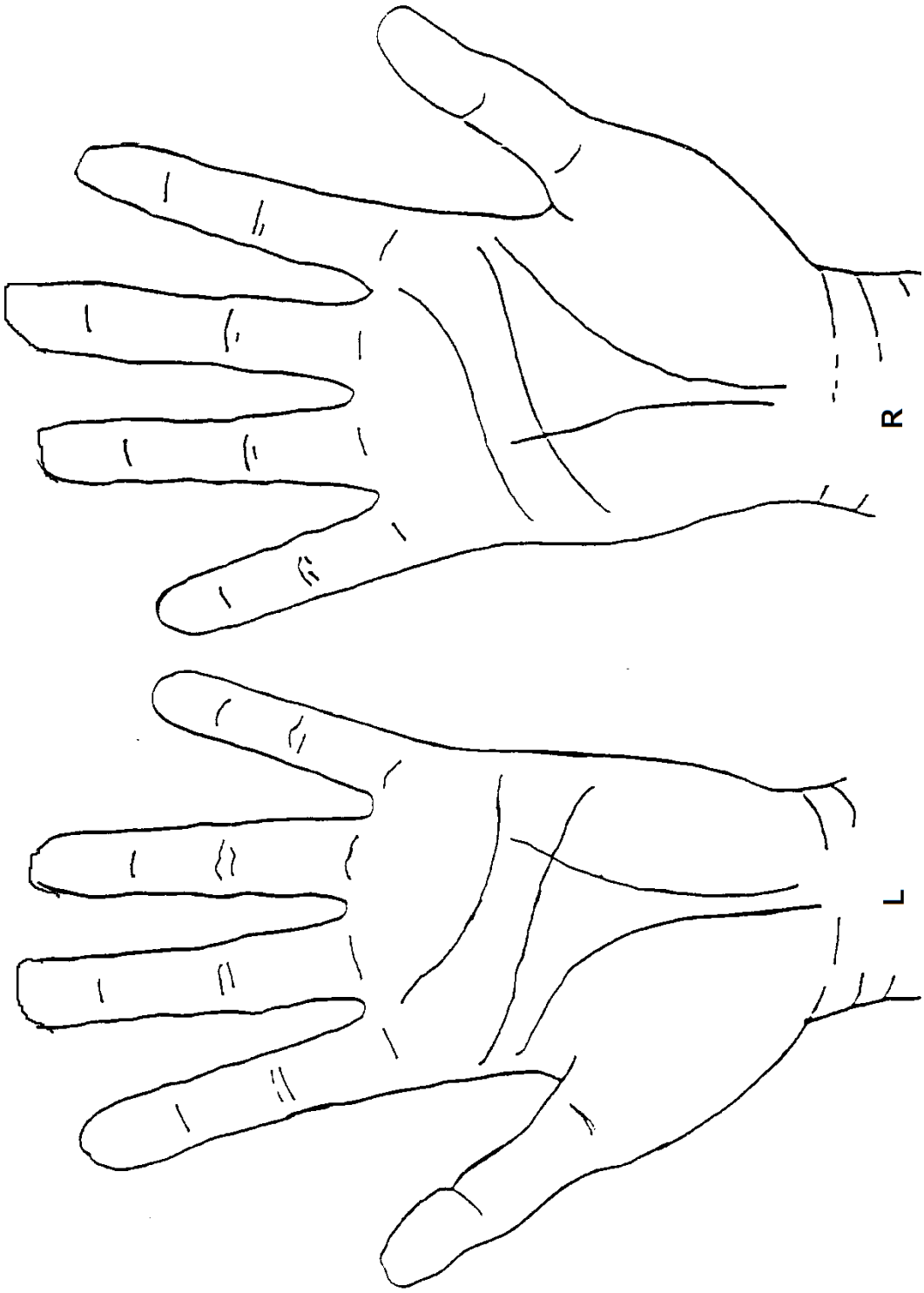
R

L R

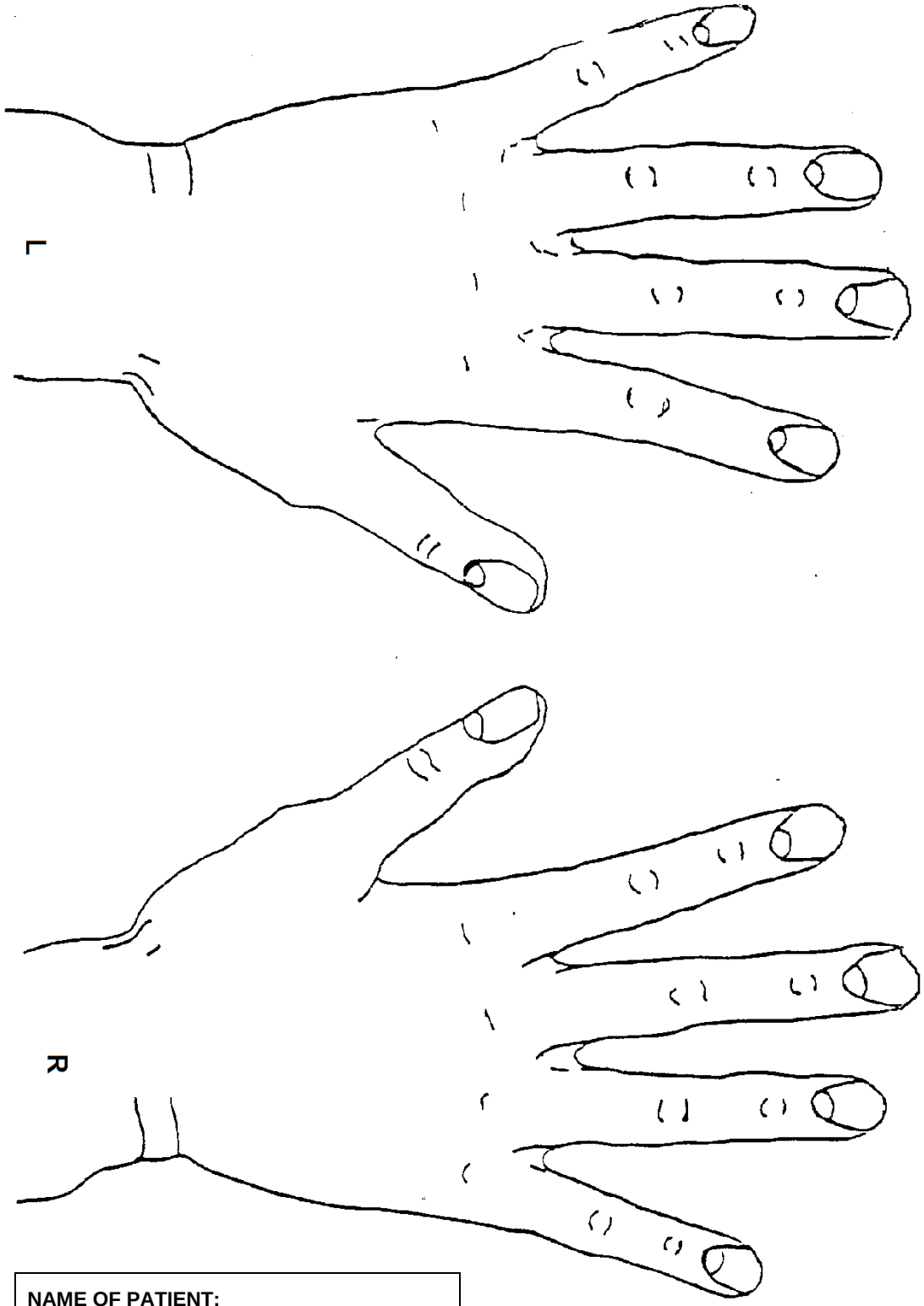
NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE

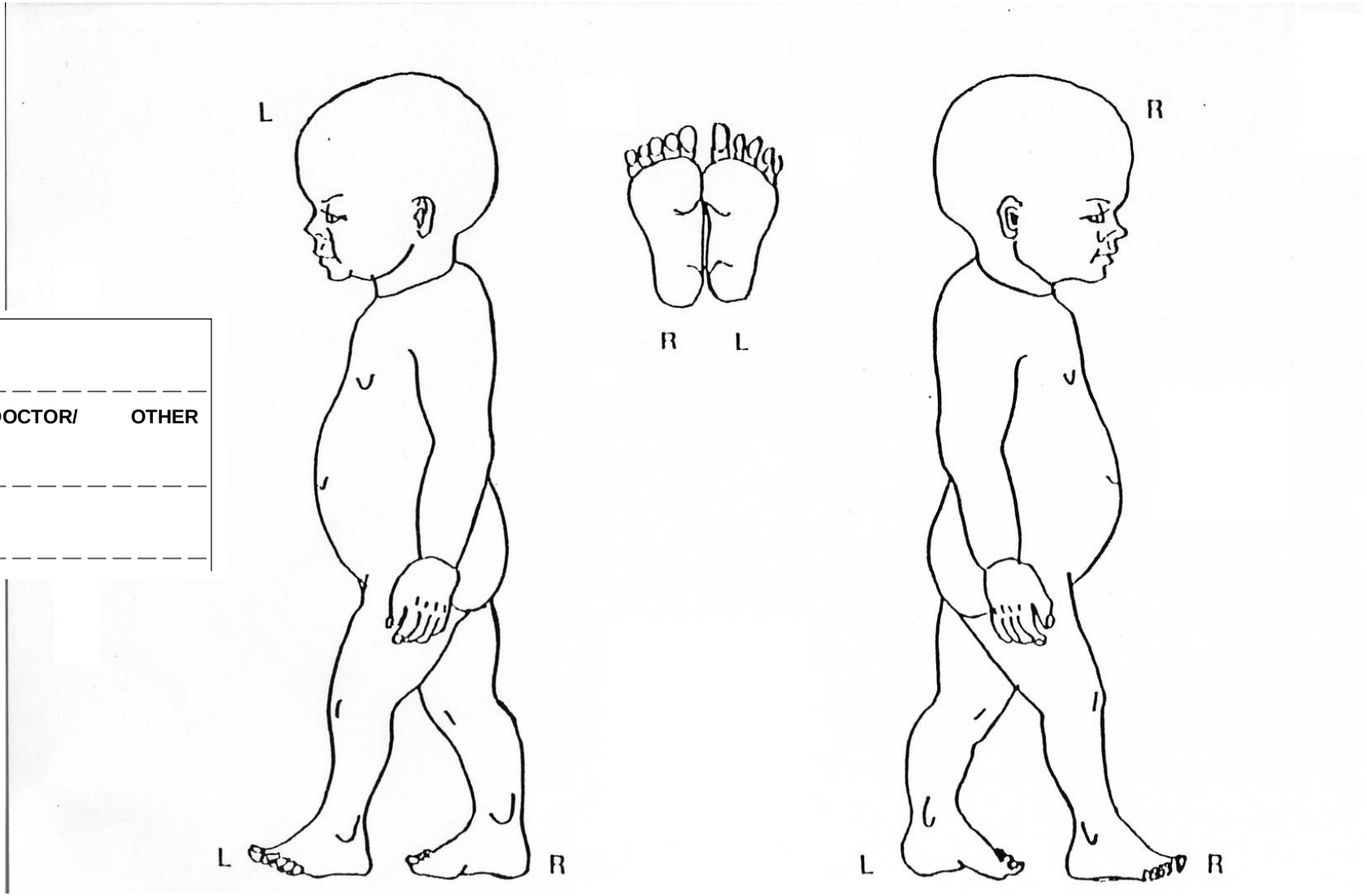


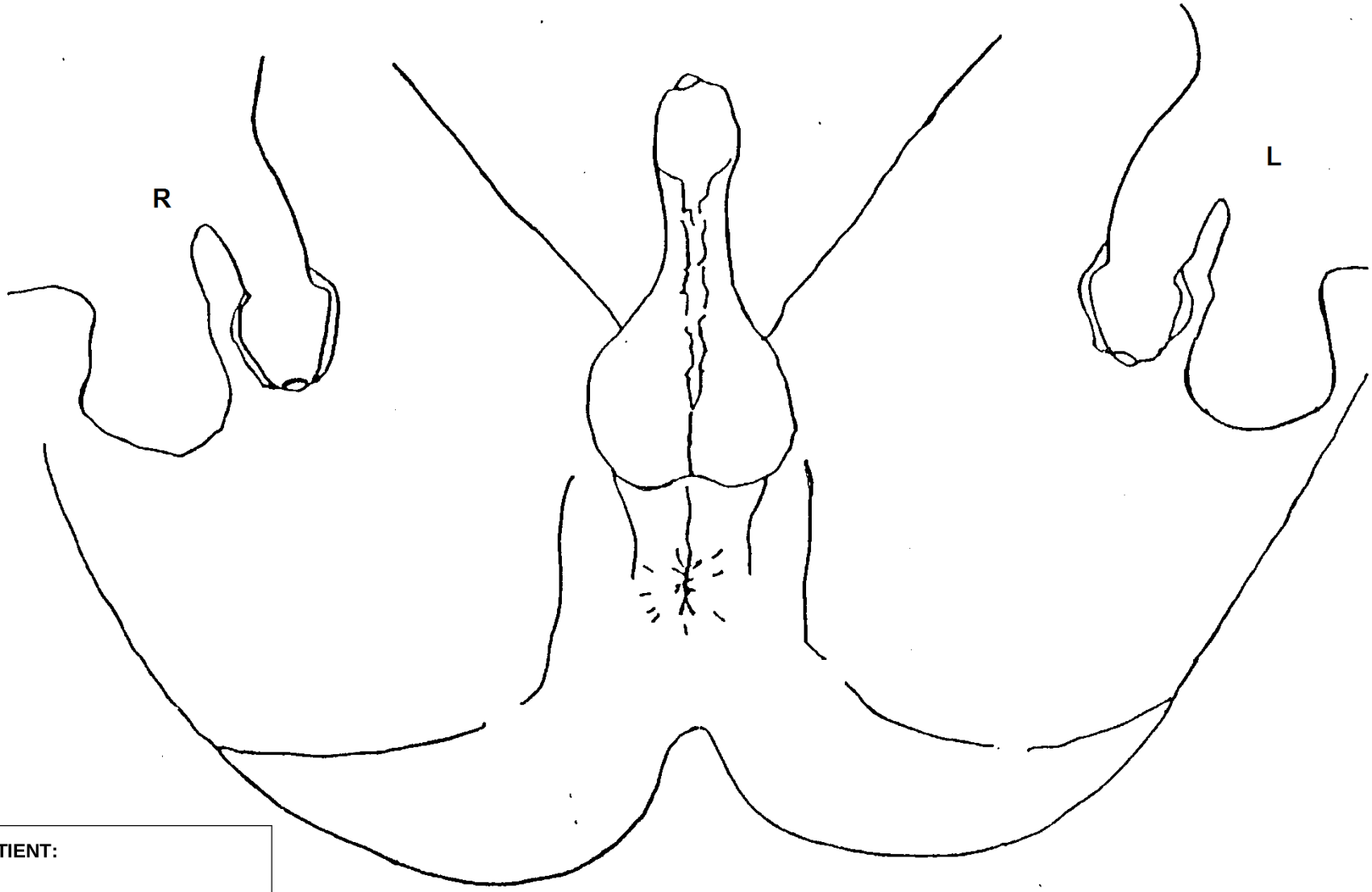
NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



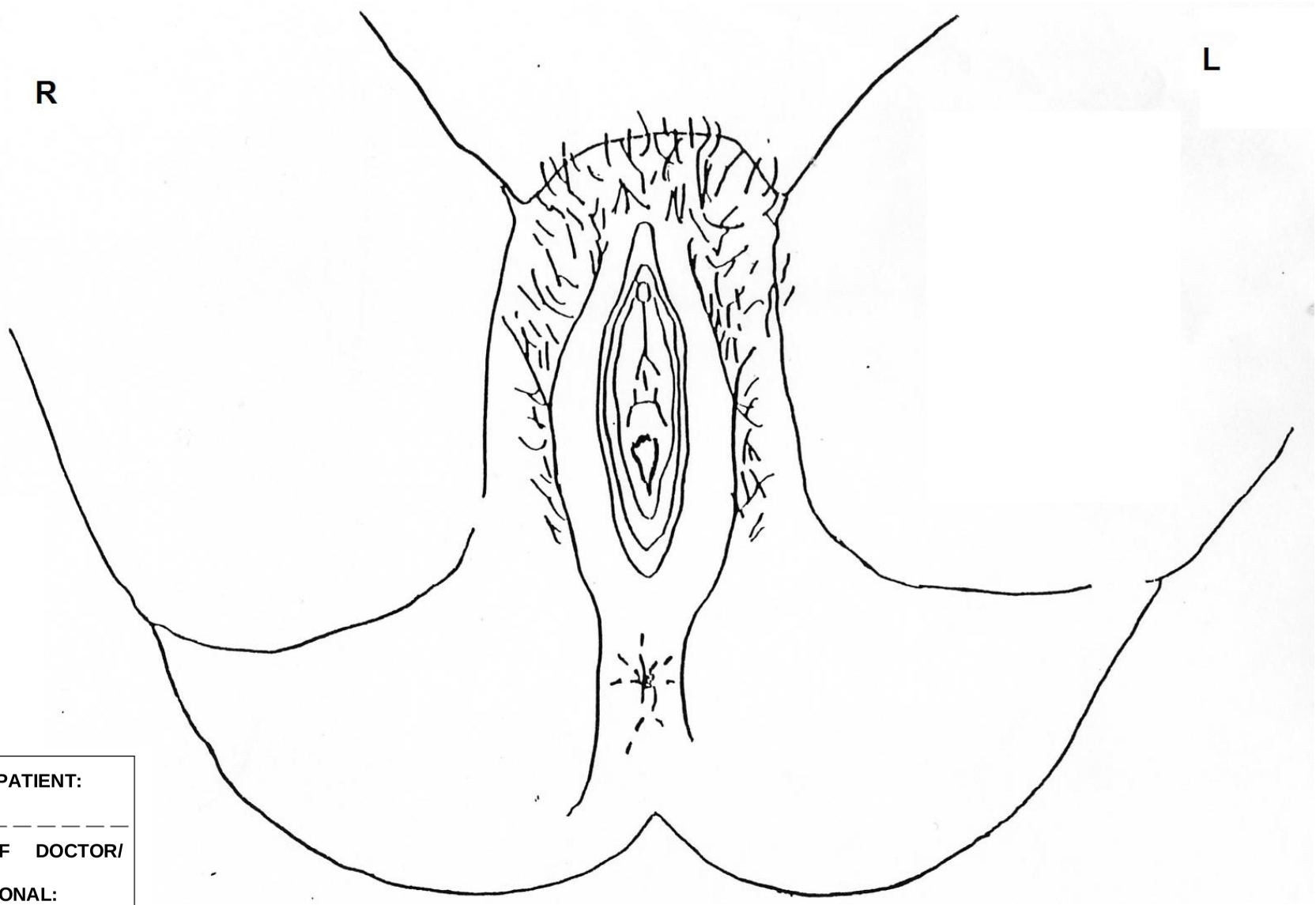
NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE

NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



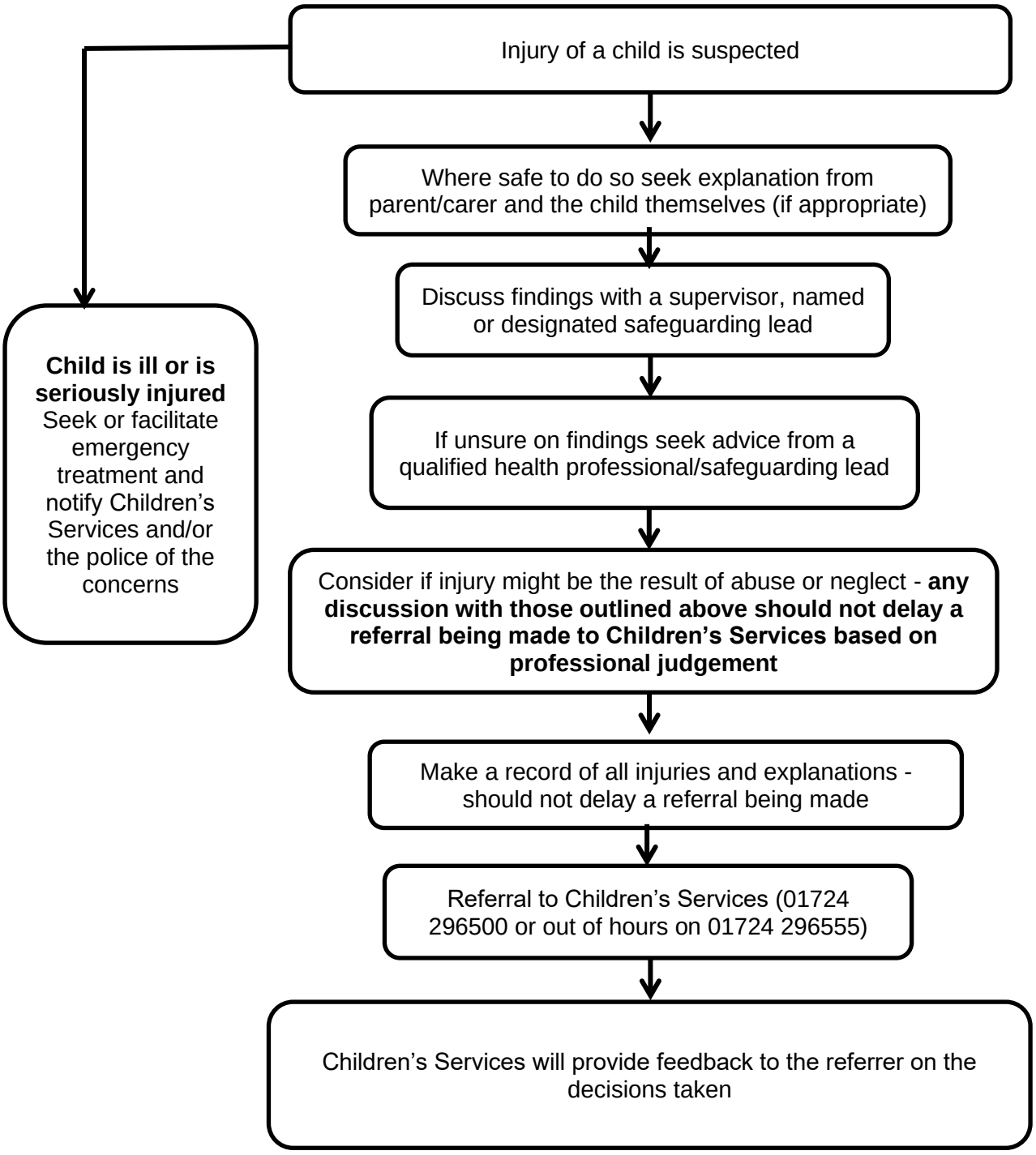


NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE



NAME OF PATIENT:
NAME OF DOCTOR/ OTHER PROFESSIONAL:
DATE

Appendix 3: Process flowchart



Appendix 4 Medical assessment

Medical assessment

The principles within this protocol will be followed and where necessary a referral will be made to Children's Services in accordance with the Children's MARS Policy and Procedures for Assessing Need and Providing Help.

Arrangements for the medical assessment

Should Children's Services decide that a strategy discussion is necessary and section 47 enquiries are initiated, consideration will be given to the child having a child protection medical assessment, undertaken by a Paediatrician. Parents/carers **must not** be asked to take the child to the hospital emergency department or to their GP as a substitute for assessment by a hospital Paediatrician.

The on call Paediatric Consultant will participate in all strategy discussions that are initiated in line with this protocol. The strategy discussion will determine, in consultation with the Paediatrician, the need and timing for a medical assessment. The consultant who has undertaken the medical will participate in all subsequent strategy discussions.

Only doctors may physically examine the whole child. All other staff should only note any visible marks or injuries on a body map and record, date and sign details in the child's file.

Consideration should be given to the gender of the examining doctors in consultation with the child and the parents/carers.

Wherever possible, the examination should be attended by a member of Children's Services staff who are familiar with the family. However, in cases where this is not possible e.g. with a family who are not previously known to Children's Services, the worker(s) attending with the family should be fully familiar with the referral that has been made and the nature of the suspected injury. The Paediatrician requires a full picture of the concerns in order to complete their examination and has the right to decline to undertake the medical examination, if no clear history is available. The worker attending should remain with the child or family until the medical has been completed and a joint plan made for the safety of the child.

It is imperative that the parent/guardian who is providing consent is present at the medical examination. If this person is unavailable, the attending social worker should have obtained written consent from the parent/guardian before the medical examination. The Paediatrician should be satisfied that the child (if appropriate) and parent has understood the purpose of the examination, what it will involve and how the results might be used. The child will not be examined and the appointment cancelled if appropriate consent is unavailable.

In some cases, e.g. where the injury was identified within a hospital setting, the child may have already been seen by a Paediatrician prior to the referral. Where this is the case Children's Services should decide whether a strategy discussion will be held and include the Paediatrician, police and relevant others in order for the medical findings to be considered.

The purpose of the medical assessment is to assess the health and wellbeing of the child, to establish whether there is any medical evidence of abuse or neglect and to initiate treatment as required.

The expected outcomes of a medical assessment include:

- an assessment of the child's health and development
- advice regarding treatment, investigation or intervention
- reassurance to the child and parents/guardian about any medical findings and any future implications
- a record of any physical findings, including written notes, drawings, photographs, video recordings or samples
- to establish whether the account given for any observed injury or harm is consistent with the injury or harm sustained
- reports and statements as required by the investigation team
- information sharing with the child's GP and other relevant health professionals
- providing continuing medical care or making referrals to relevant health service colleagues

The Paediatrician should arrange for additional medical investigations if the circumstances warrant this.

Documentation and communication

The examining Paediatrician will provide any attending social worker with an immediate handwritten copy of pages 16-17 from Northern Lincolnshire and Goole NHS Foundation Trust's Assessment of Referral for Child Protection Concerns which provides a medical summary and an initial view on causality / whether the injury may be non-accidental or unexplained.

The examining Paediatrician should provide a fully typed report within 5 working days from the examination. See the Initial Paediatric Report format below.

Where a report cannot be provided within timescales, the **clinical** reason for this must be made clear to the referring agency.

The examining Paediatrician will be responsible for the distribution of the report to other appropriate agencies e.g., GP, Children's Services, Named Professional for Safeguarding and the police.

Where there is a need for ongoing medical investigations, it is the responsibility of the Paediatric Consultant in charge of the case to ensure that multi-agency partners are kept informed of the results.

Content of the report

The report should include:

- a verbatim record of the parents/carer's and child's accounts of the injuries and the concerns noting any discrepancies or changes of story
- the documentary findings
- the site, size and shape of any marks or injuries, including those which may be considered accidental
- the opinion of whether, and which, injuries are consistent with explanation(s), or perceived to be of concern
- the date, time and place of examination
- those present

- who gave consent and how (child / parent / carer, written / verbal)
- other findings relevant to the child (e.g. squint, learning or speech problems etc)
- confirmation of the child's developmental progress (especially important in cases of neglect)
- the time the examination ended

All reports and diagrams should be signed and dated by the doctor undertaking the examination.

Consent

Information about the medical assessment will be given to the parents/carers and child by the Paediatrician completing the medical when the child and family attend the appointment.

The social worker must obtain written consent for the medical assessment if the child is not being accompanied to the medical by a person who has parental responsibility. It is the responsibility of the examining doctor to ensure that this written informed consent is obtained before proceeding with the examination. If consent to medical assessment is not available or cannot be obtained, then the examining doctor may consider it appropriate to continue the assessment in order to facilitate the safeguarding of the child.

The following person(s) may give consent:

- A child of 16 years and over (unless lacking mental capacity)
- A child under 16 who is able to fully understand what is proposed and its implications (often referred to as Gillick/Fraser competence). The more serious the circumstances, the greater the need for the child to have a full understanding of the implications, otherwise the consent may be held to be invalid. However, the Paediatrician must always make a judgement and act in the best interests of the child. This may include going ahead with the medical assessment. If in doubt the examining doctor should discuss with the consultant on call (if this is a different person to the one completing the medical)
- Any person with parental responsibility. When a child is subject to a Care Order, the person with parental responsibility will include the Local Authority
- The Local Authority, when the child is accommodated, and the parent/carer has abandoned the child or are physically or mentally unable to give such authority
- The court, when a child is subject to an Interim Care Order, Emergency Protection Order or Child Assessment Order. Note that consent for examination or assessment requires the court to make specific direction.

Police Powers of Protection do not give parental responsibility to the Local Authority (or the police), therefore if a person with parental responsibility or the child if judged as Gillick/Fraser competent, does not give medical consent then the medical assessment cannot proceed unless considered in the best interests of the child.

Siblings

Consideration should be given to whether siblings of the subject child also need a medical examination as part of the child protection enquiry, even though there are no obvious signs of injury/abuse in that child. The strategy discussion must consider whether these examinations also need to occur within 24 hours. Should the decision be made to postpone or not to proceed with sibling medicals the decision and risk assessment should be clearly documented.

Decision making

The key principle of this protocol is that where a baby or child, particularly where they are not independently mobile, has sustained injuries as outlined in this document, decisions should **not** be made by a practitioner in isolation.

Where possible, decisions should be made by two practitioners/professionals (one of which should be a named or designated safeguarding lead or qualified health professional).

It should however be noted that this protocol does not seek to remove or undermine professional judgement, but instead support practitioners in making important decisions when safeguarding children. This includes making a referral to Children's Services based on their own professional judgement and without discussion with the above professionals, if this is not possible, or a referral needs to be made immediately.

Where a section 47 enquiry has been undertaken, the assessment should form a view regarding whether the concerns of significant harm are not substantiated or whether the concerns of significant harm are substantiated, and the child is judged to be suffering or likely to suffer significant harm. All partner information and analysis should inform the assessment outcome.

In some cases, the outcomes of the section 47 enquiry may not be clear e.g. the findings of the paediatric assessment may be inconclusive or agencies may hold differing views about the level of risk. In such cases, a further strategy discussion could be held, chaired by a Service Manager or Practice Supervisor from Children's Services. The process of bringing the relevant professionals together to discuss the case may contribute to better assessment and outcomes.

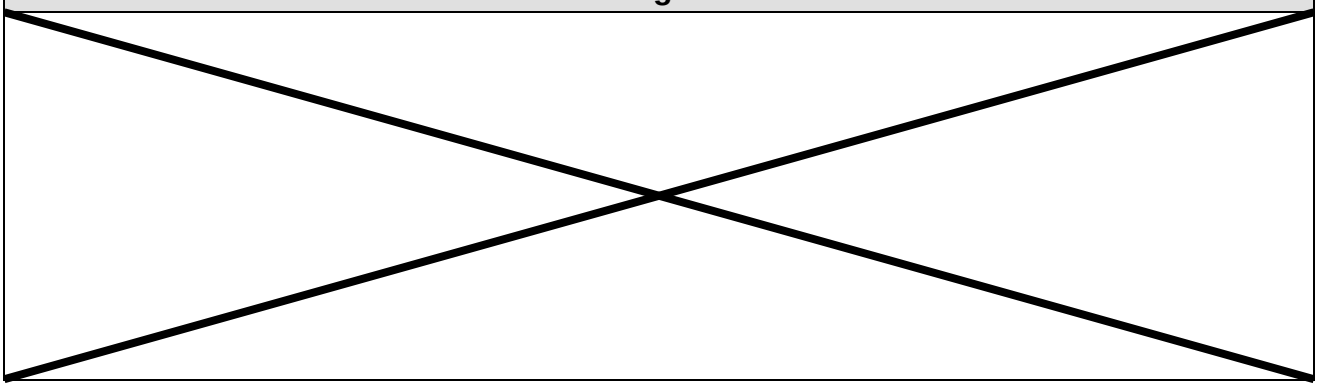
This assessment will inform the action to be taken by Children's Services and/or the police.

Children's Services should also ensure that the outcomes of the section 47 enquiry are shared with the family (unless to do so would place the child at risk) and all relevant partners.

In all agencies, the outcomes of the section 47 enquiry should be recorded in detail. This is particularly important where a decision is taken that no further action is required to protect the baby or child.

Initial Paediatric Report format

Name:	DOB:	NHS No:

Investigations


Summary

(Brief summary of the assessment. Incorporate relevant positive and negative information)

Name:	DOB:	NHS No:

Opinion / Conclusion

(comment on likelihood of NAI with supportive explanations from history, examination and evidence)

Discussion with On-Call / On Service Consultant

Plan

(As discussed with consultant, social worker and parent / carer. Include admission to hospital or place of safety, recommendation regarding sibling examination, child protection conference and follow up)