North Lincolnshire
CHILDREN'S MULTI-AGENCY RESILIENCE & SAFEGUARDING BOARD

Children's MARS Guidance

Bruising and injuries in infants and children (including those that are non-independently mobile)

February 2024

Contents

Introduction

This guidance is relevant to practitioners who come into contact with infants and children. It provides advice on what to do following the identification of bruising or injuries to infants and children including those that are non-independently mobile.

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, mark on the skin that might look like bruising or other injury in a child of any age 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 guidance.

It is recognised that a small percentage of bruising in non-independently mobile infants 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 they should remain alert to signs of abuse, unexplained or unusual injuries or injuries where the explanation provided is not congruent with the injury sustained.

This guidance takes into account the briefing from the Child Safeguarding Practice Review Panel on Bruising in non-mobile infants, September 2022.

Definitions

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

Non-independently mobile infant or child
An infant or child who is unable to move independently through crawling, cruising or bottom shuffling. Particular attention should be given to the risks in those children who are unable to roll over.

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.

Non-accidental injury
Damage, e.g. bruise, burn, scald, fracture - deliberately inflicted

Definitions of other types of injuries can be found in Appendix 1

Evidence base

The Child Safeguarding Practice Review Panel briefing paper on bruising in non-mobile infants says that:

The most comprehensive summary of the current evidence is contained within the Child Protection Evidence Systematic Review on Bruising (Royal College of Paediatrics and Child Health, 2020) 1 (RCPCH). This is based on an original systematic review completed in 2005 and regularly updated. It incorporates scientific literature on abusive and non-abusive bruising in children. The systematic review concludes that:

'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.'

A review of the studies included in this systematic review suggest that accidental bruising is uncommon in pre-mobile infants, particularly in those who are younger, unable to roll and unable to crawl. However, accidental bruising in pre-mobile infants is not unknown, with the numbers found to have a bruise on a single observation ranging from 0.6-5.3% in those who were not yet rolling or crawling. Accidental bruising is more common in more mobile children, in one study being found in up to 17.3% of those who were crawling but not yet cruising, and 17.8% in those who were crawling and cruising but not yet walking.

Areas to consider

You should consider:

- **Age and mobility of the child**
  Non-independently mobile infants and children are at greater risk of non-accidental injury
- **Explanation of injury**
  Is explanation / history provided by the parent/carer consistent with the presenting injury
- **Child's development**
  Is the child's development consistent with the presenting injury
- **Severity of injury and any additional bruising/injuries**
- **Any unexplained delay in presentation or explanation for delay unsuitable**
- **Any additional safeguarding history**
  The bruising or injury should be assessed in the context of personal, family and environmental history to ensure that it is consistent with an innocent explanation
- **Child's demeanour/presentation**

Practitioners must be professionally curious to determine further information in the interests of the child. A satisfactory explanation should be sought and the characteristics of the bruising or injury should be assessed and the distribution carefully recorded.

Bruising to very young babies may be caused by medical issues e.g. birth trauma, however this is rare. Birthmarks may also be present at birth and can appear in the early weeks and

months after birth. This should be documented in the child's medical notes and parent held records.

In addition, some medical conditions can cause marks to the skin in very young babies that may resemble a bruise.

In all cases, unless the specific mark that has been identified has been confirmed as arising from birth trauma, birthmark or a medical condition, this guidance should be followed to enable multi-agency consideration of the suspected bruising or injury.

There may also be occasions where an explanation is given that another child has caused the injury. This should still be further explored taking into account this guidance.

Actions to be taken

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.

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. They should also notify Children's Services.

If a practitioner has concerns about a child's welfare or that the child has suffered or is likely to suffer significant harm, they should share the information with or make a contact/referral to Children's Services.

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 a bruise or injury, they should seek an explanation from the parent/carer, and where possible, from the child themselves. All people who live within the family home or participate in any aspect of the child's care, should be considered.

If a contact/referral is being made, parent/carer consent should be obtained unless the practitioner identifies to do so would jeopardise information gathering (e.g., information or evidence could be destroyed) or if it would place the child at risk.

Further detail in relation to making a contact/referral, 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.

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

Bruising or injuries in non-independently mobile infants and children

Where a practitioner identifies a bruise or injury to an infant or child who is **non-independently mobile**, in **all** cases they must make a contact/referral to Children's Services.

The Child Safeguarding Practice Review Panel recommends that in **all** cases of bruising or injuries in infants and children who are ***not independently mobile*** *there is:*

- *a review by a health professional who has the appropriate expertise to assess the nature and presentation of the bruise, any associated injuries, and to appraise the circumstances of the presentation including the developmental stage of the child, whether there is any evidence of a medical condition that could have caused or contributed to the bruising, or a plausible explanation for the bruising*

- *a multi-agency discussion to consider any other information on the child and family and any known risks, and to jointly decide whether any further assessment, investigation or action is needed to support the family or protect the child. This multi-agency discussion should always include the health professional who reviewed the child*

Practice arrangements for bruising or injuries in non-independently mobile infants and children

In line with the evidence base and Child Safeguarding Practice Review Panel recommendations, a paediatric initial medical review will be completed by a Paediatrician and referral will be made to children's services for **all** non-independently mobile infants and children that present with bruising or injuries. Following the initial medical review there will be a multi agency discussion or meeting including the Paediatrician that will share information and jointly decide whether there is a need for progression to a strategy discussion. The strategy discussion will consider whether a section 47 enquiry is undertaken and the requirement for a child protection medical or not.

The initial medical review only applies for **non-independently mobile** infants and children that present with bruising or injuries.

For bruising or injuries in non-independently mobile infants and children please follow flowchart 1 contained in Appendix 2.

Parents/carers **must not** be asked to take the infant or child to the hospital emergency department or to their GP as a substitute for assessment by a hospital Paediatrician.

Suspected non-accidental bruising and injuries in independently mobile children

Any suspected non-accidental bruising or injury to an independently mobile child should be discussed with a supervisor, named or designated safeguarding lead. The practitioner should consider seeking advice from a qualified health professional if further support is required.

Practitioners should not make the decision alone that the explanation offered by parents/carers or others, explains the bruising or injuries sustained to the 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 contact/referral being made to Children's Services.

For suspected non-accidental bruising and injuries in independently mobile children please follow flowchart 2 contained in Appendix 2.

Recording

In all cases, contemporary, comprehensive, accurate, dated, timed records should be kept.

Mapping, description and recording of the size, colour, characteristics of bruising/injuries, including site, pattern and number should be made on a body map.

A careful record of parent/carers description of events and explanation for the bruising or injury should be made in the notes. If ascertained, this should include the description of events and explanation of all people who participate in any aspect of the child's care. Template body maps can be found in Appendix 3.

Strategy discussion, section 47 enquiry and child protection medical

The on call Paediatric Consultant will participate in all strategy discussions and/or multi-agency discussions where possible that are initiated in line with this guidance. The strategy discussion in consultation with the Paediatrician and multi-agency partners will determine the need for progression to a section 47 enquiry with a child protection medical as part of the enquiry.

The child protection medical physical examination will be completed as soon as possible or within 24 hours of the request from the strategy discussion. The timing of the child protection medical will be on a case by case basis and based on clinical need. Children's Services will liaise with the Paediatrician who has undertaken the child protection medical to arrange a date and time for subsequent strategy discussions and/or multi agency discussions.

Wherever possible, the examination should be attended by a member of Children's Services staff who are familiar with the child. 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 child should be fully familiar with the referral that has been made and the nature of the suspected bruise or injury. The Paediatrician requires a full picture of the concerns in order to complete their examination and may 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 which may be that the child remains in hospital.

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

Consent

The member of Children's Services staff attending the appointment must obtain written consent for the medical assessment if the child is not being accompanied by a person who has parental responsibility. It is the responsibility of the examining Paediatrician to ensure that this written informed consent is obtained before proceeding with the examination. If consent to medical assessment is not available, refused or cannot be obtained from either the child/parent/carer, then the examining Paediatrician will need to refer to the Trust's 'policy for consent to Examination or Treatment', RCPCH guidance, and discuss with Safeguarding Named and Designated Consultants including the Trust legal team if required.

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. If in doubt the examining Paediatrician will need to refer to the Trusts 'policy for consent to Examination or Treatment', RCPCH guidance and discuss with named and designated professionals including the Trusts legal team if required
- Any person with parental responsibility. When a child is subject to a Care Order, Interim Care Order or Emergency Protection Order parental responsibility is held by the local authority
- A person with a Residence or Special Guardianship Order from the court has parental responsibility
- Adoptive parents have parental responsibility, and the birth parents cease to have such from the moment that the Adoption Order is made
- When a child is accommodated by agreement (section 20 Children Act 1989), the parents (and others with parental responsibility) retain parental responsibility and the local authority does not have parental responsibility
- The court, when a child is subject to a Child Assessment Order. Note that consent for examination or assessment requires the court to make specific direction

If a person with parental responsibility refuses to give consent and it is believed that the child is at immediate risk of harm, the local authority should be informed that consent has been refused. The local authority will then decide whether to issue legal proceedings and obtain the relevent court order with a direction from the court authorising the medical assessment.

Police powers of protection do not give parental responsibility to the local authority (or the police).

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 or member of Children's Services staff 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/guardian has understood the purpose of the examination, what it will involve and how the results might be used.

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

Purpose of the child protection medical

The purpose of the child protection medical 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:

- if developmental delay is noted during the medical assessment, a referral will be made by the consultant Paediatrician for a full development assessment
- advice regarding treatment, investigation or intervention
- reassurance to the child and parent/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 bruise/injury is consistent with the bruise or injury 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 the attending Social Worker or member of Children's Services staff with an immediate handwritten copy of the Safeguarding Children Medical Proforma which provides a body map, medical summary and an initial view on causality/ whether the bruising or injury may be non-accidental or unexplained.

The examining Paediatrician should provide a fully typed initial report between 5-10 working days from the examination or sooner if possible depending on the specifics of the case. Following the initial report, if further tests are required, an addendum to this report will be provided as soon as possible. This is to provide the results of the medical investigations (for example skeletal survey and extended blood clotting screening) that will not be available at 10 days.

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 at the hospital 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 parent/carer's and child's accounts of the bruising or injuries and the concerns noting any discrepancies or changes of story
- the documentary findings
- the site, size and shape of any marks or bruising or injuries, including those which may be considered accidental
- the opinion of whether, and which, bruising or 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 body maps should be signed and dated by the Paediatrician undertaking the examination.

Siblings

Consideration should be given as to whether siblings of the subject child also need a medical examination even though there are no obvious signs of injury/abuse in that child. The strategy discussion or multi-agency 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 medical assessments the decision and risk assessment should be clearly documented.

Differences of opinion

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

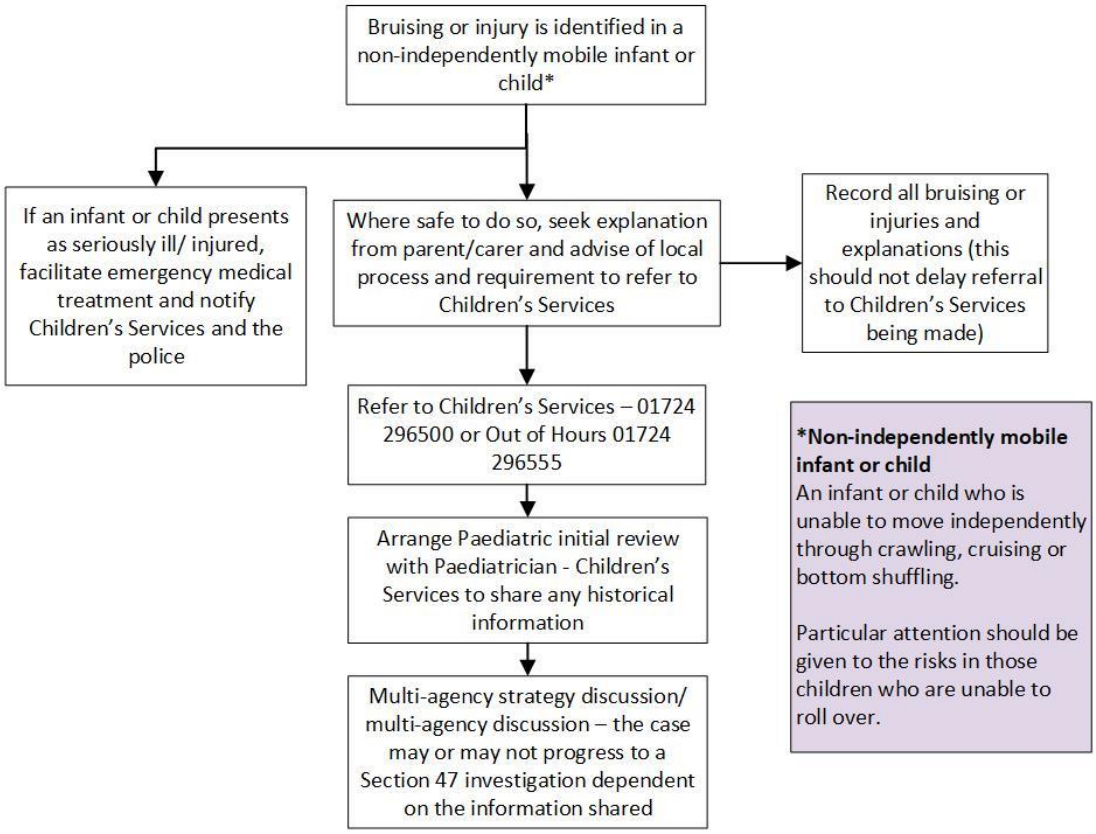
Appendix 1: Types of injuries

Type of injury	Definition
Abrasion	An area damaged by scraping or wearing away Synonyms include graze, scrape, scratch, cut, gash, laceration, injury, contusion
Bruise	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. Synonyms include contusion, lesion, mark, injury, skin discoloration
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
Petechiae	Red or purple spots, less than two millimetres in diameter and often presenting in clusters
Contusion	A region of injured tissue or skin in which blood capillaries have been ruptured; a bruise Synonyms include: bruise, lesion, mark, injury, skin discoloration
Cut	A long, narrow incision in the skin made by something sharp Synonyms include gash, slash, laceration, incision, wound, injury
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
Gash	A long, deep cut or wound Synonyms include laceration, cut, puncture, incision
Graze	A slight injury where the skin is scraped Synonyms include scratch, scrape, abrasion, cut, injury, sore
Laceration	A deep cut or tear in skin or flesh Synonyms include 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 Synonyms include wound, injury, bruise, abrasion, contusion, scratch, scrape, cut, gash, laceration
Scald	Tissue damage caused by applied wet heat such as hot water or steam
Scratch	A mark or wound made by scratching Synonyms include graze, scrape, abrasion, cut, laceration, wound

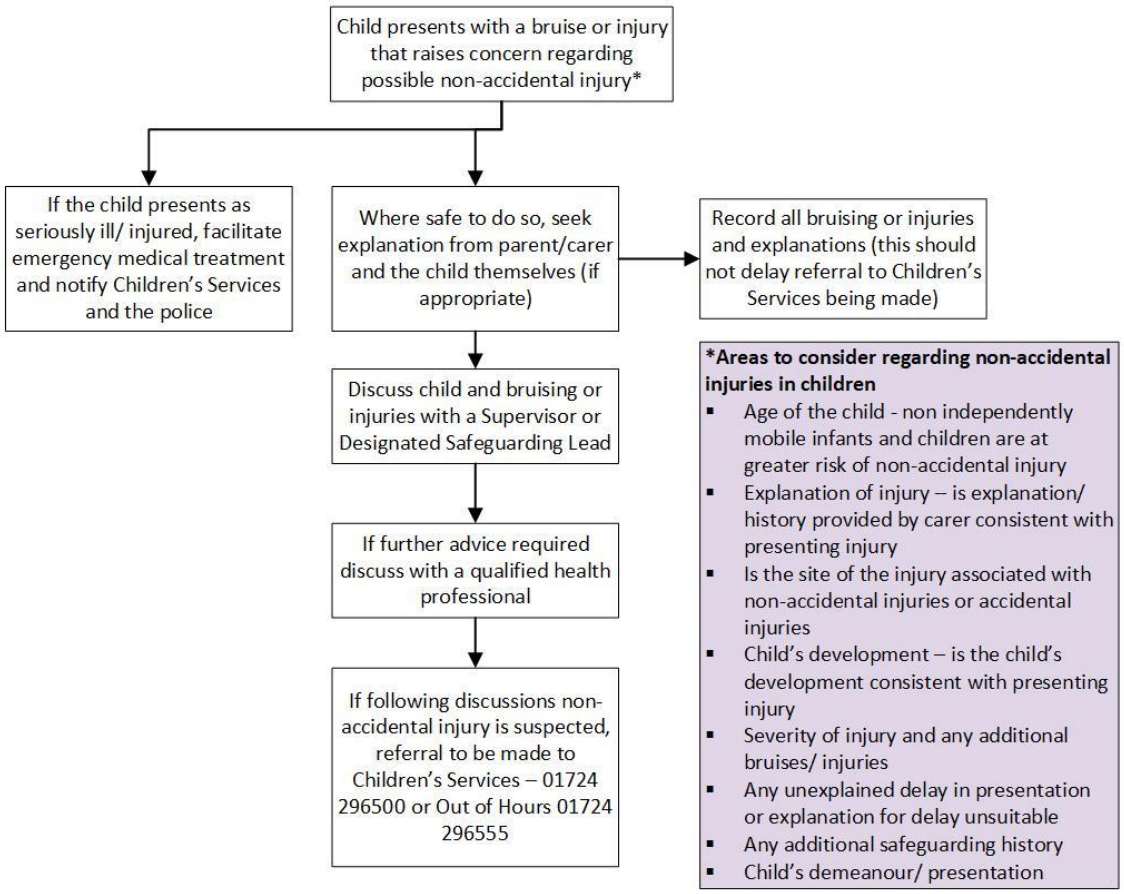
Sore	A raw or painful place on the body Synonyms include inflammation, swelling, lesion
Subconjunctival haemorrhage	Bleeding within the whites of the eyes and should be considered as similar to bruising to the eye itself for the purposes of this protocol
Wound	An injury to living tissue caused by a cut, blow, or other impact, typically one in which the skin is cut or broken Synonyms include injury, lesion, cut, gash, laceration, tear, rent, puncture, slash

Appendix 2: Process flowcharts

Flowchart 1: Bruising and injuries in non-independently mobile infants and children



Flowchart 2: Suspected non-accidental bruising and injuries in independently mobile children



Appendix 3: Body maps

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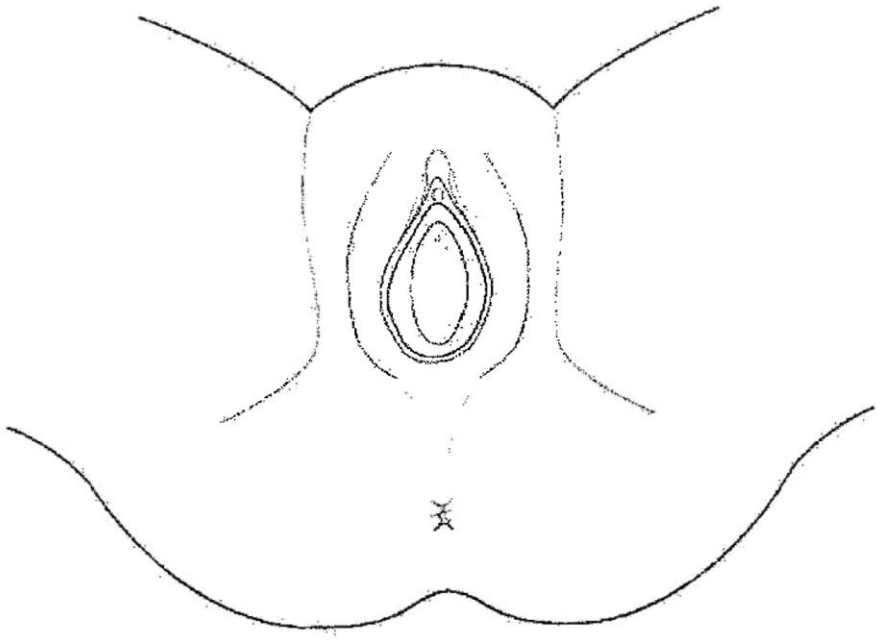

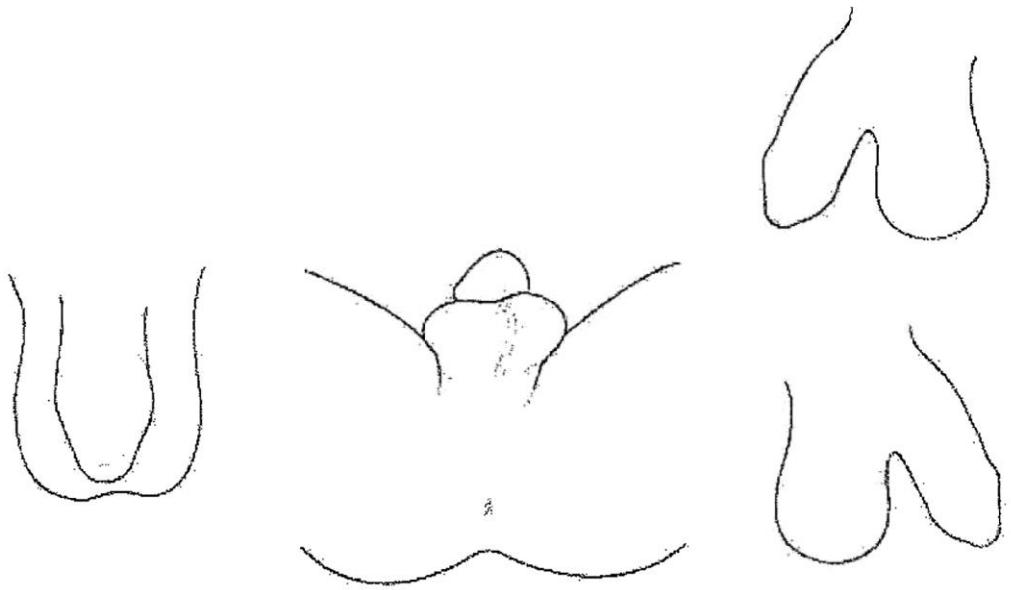

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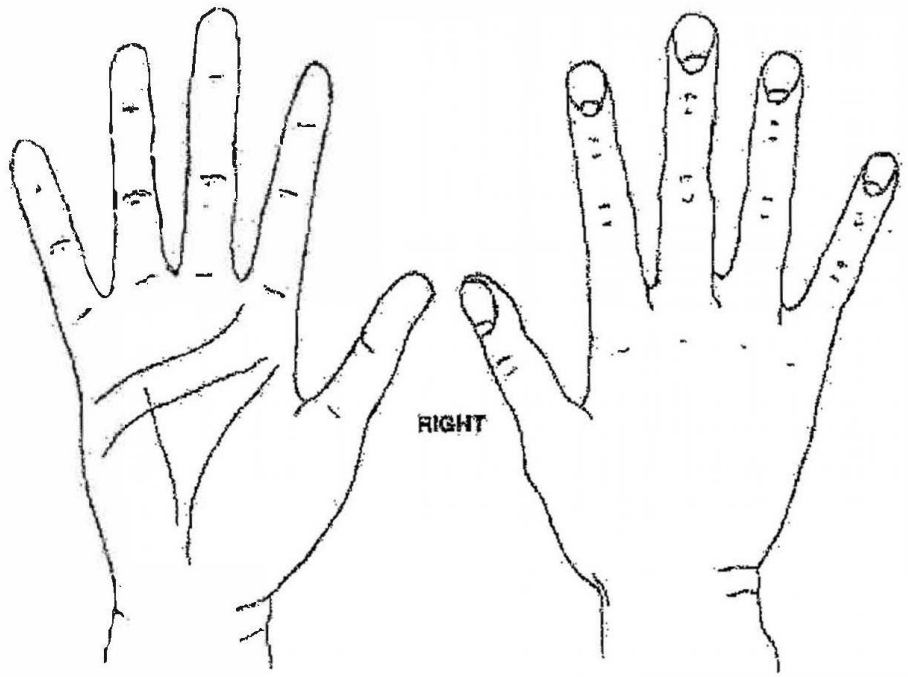

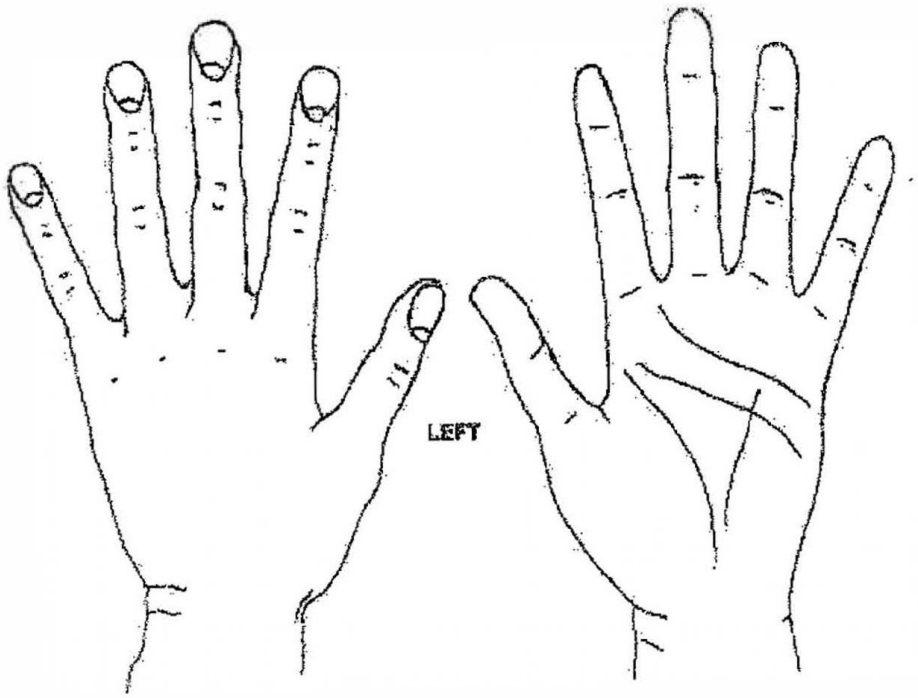

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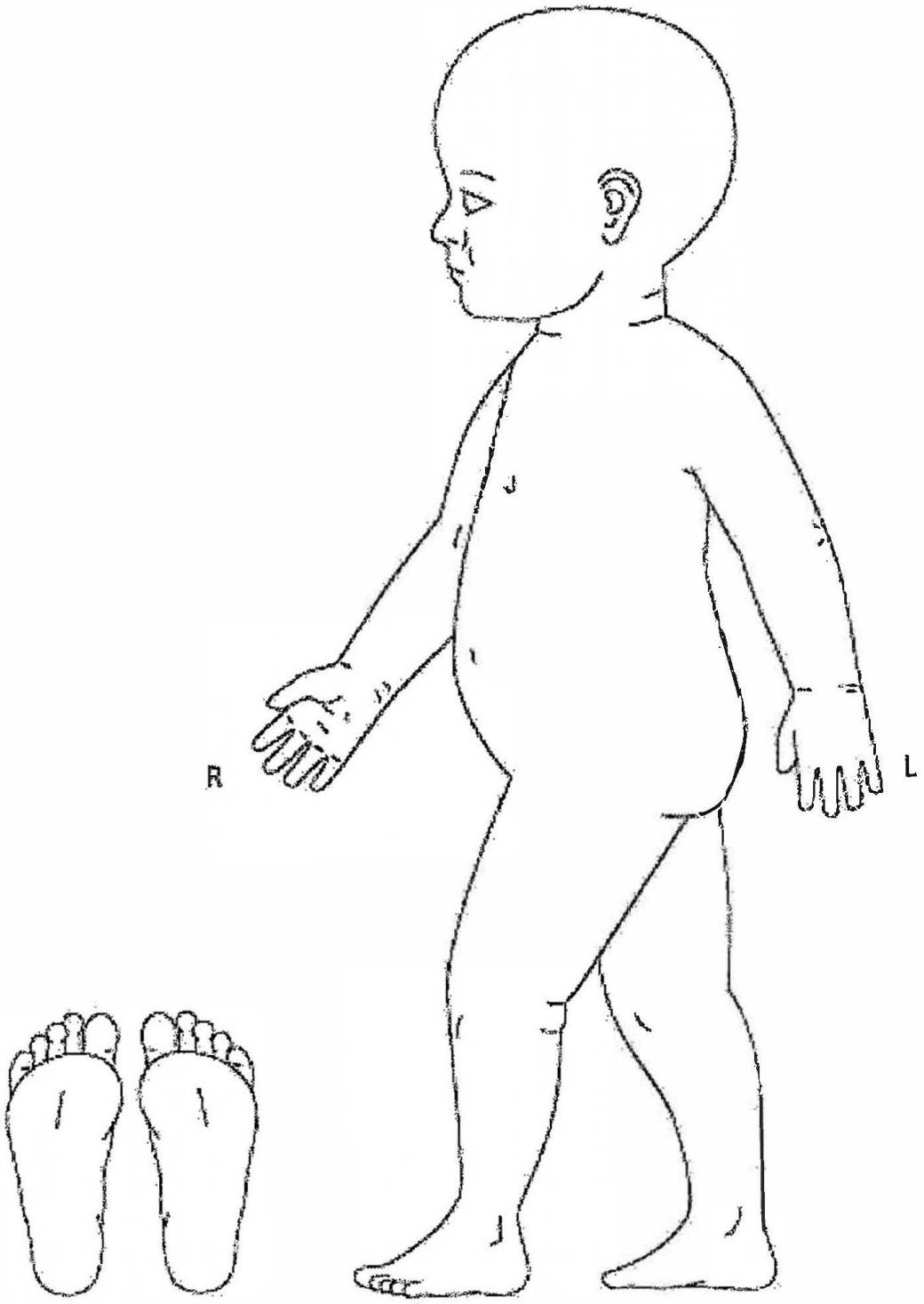

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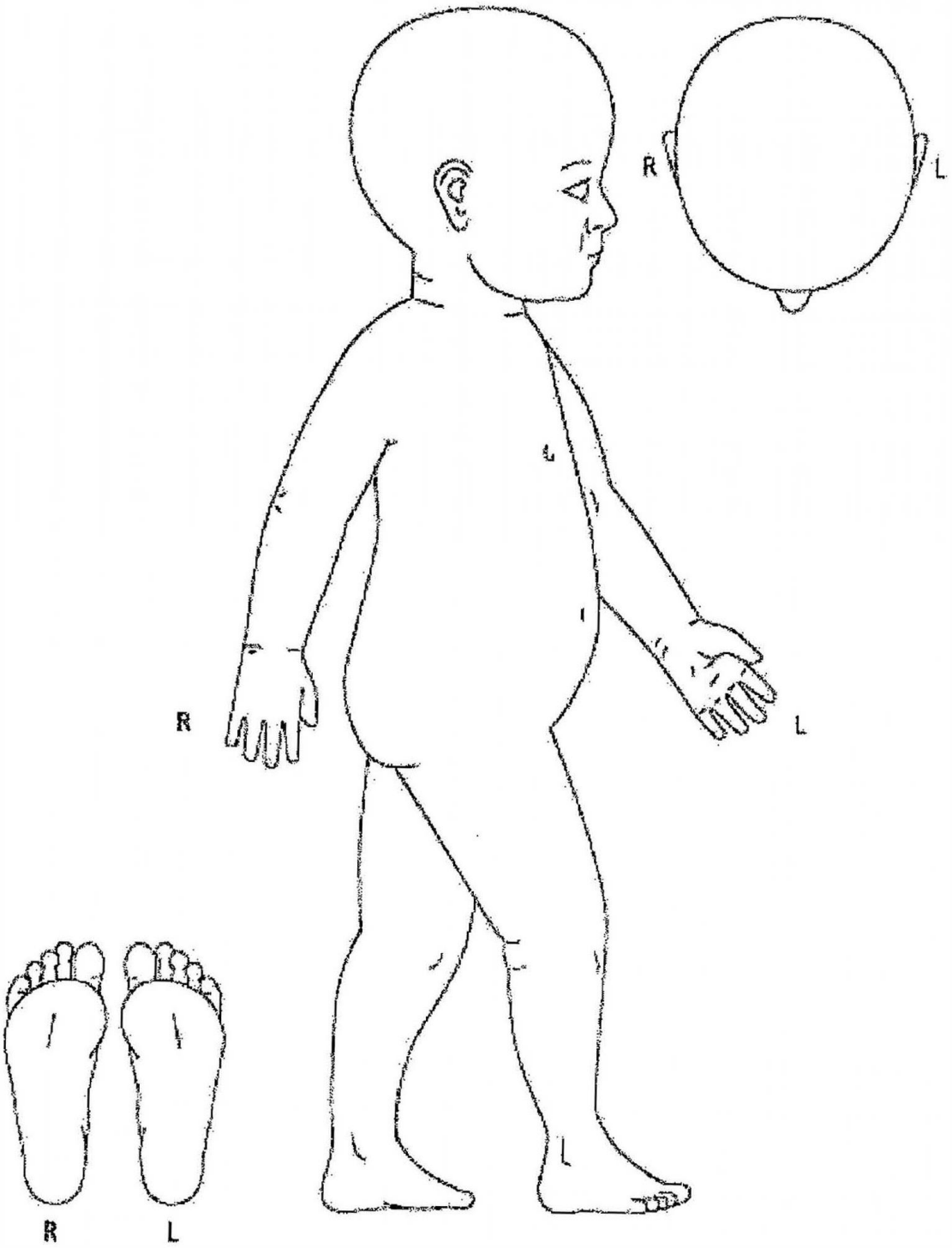

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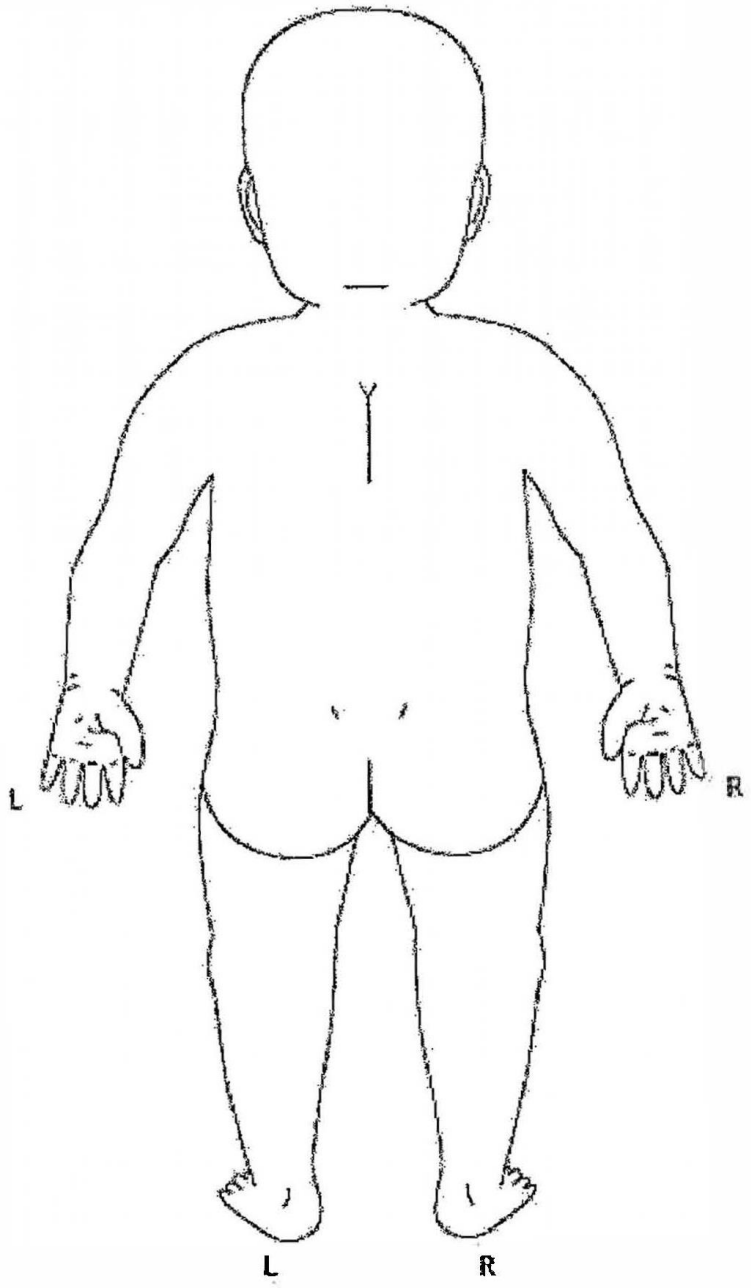

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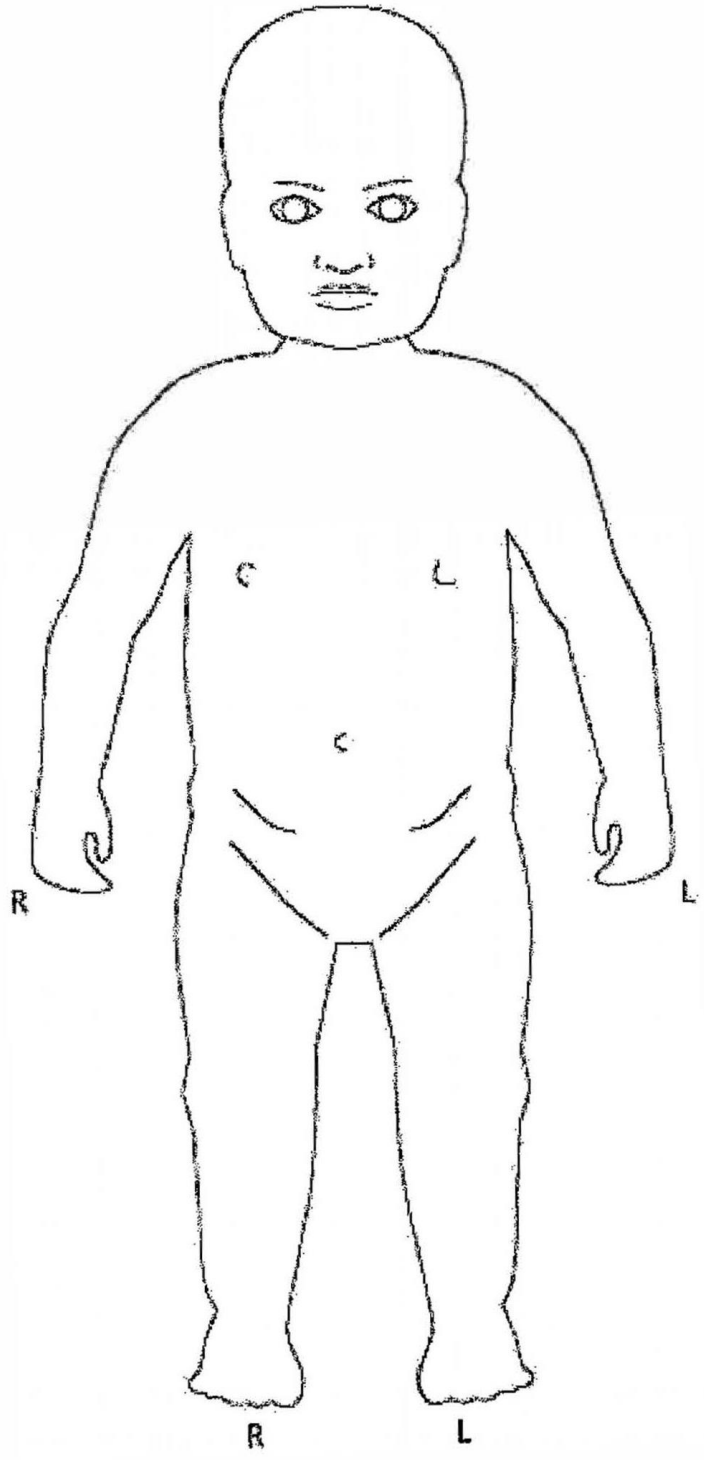

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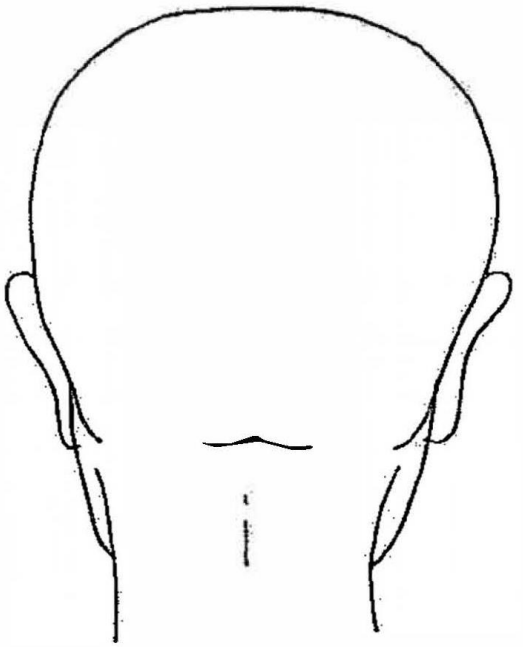

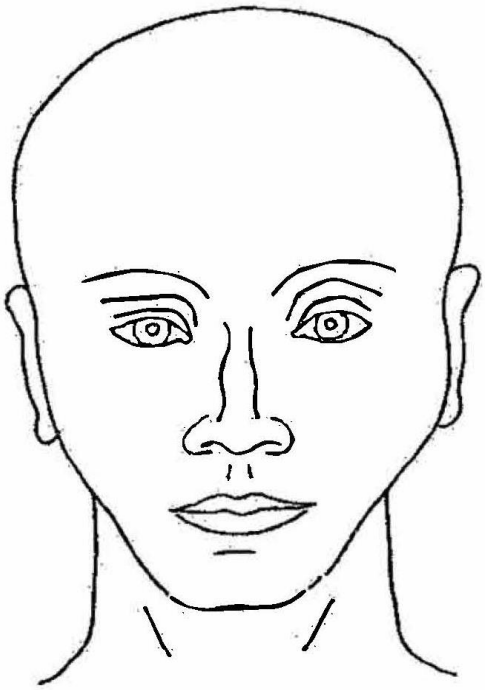

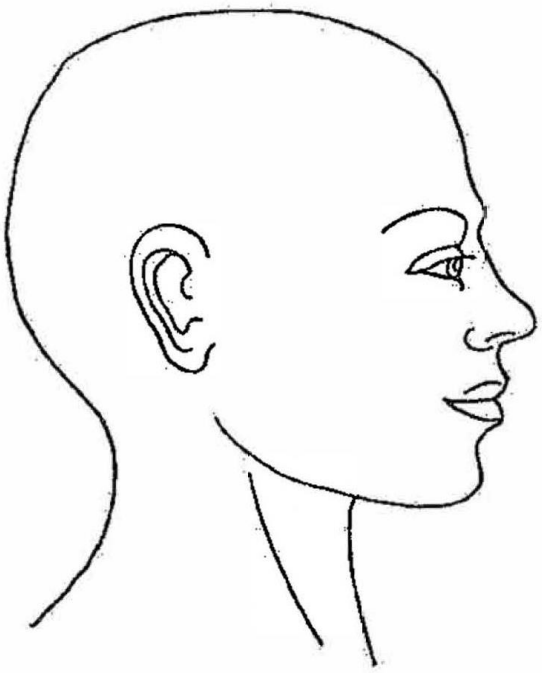

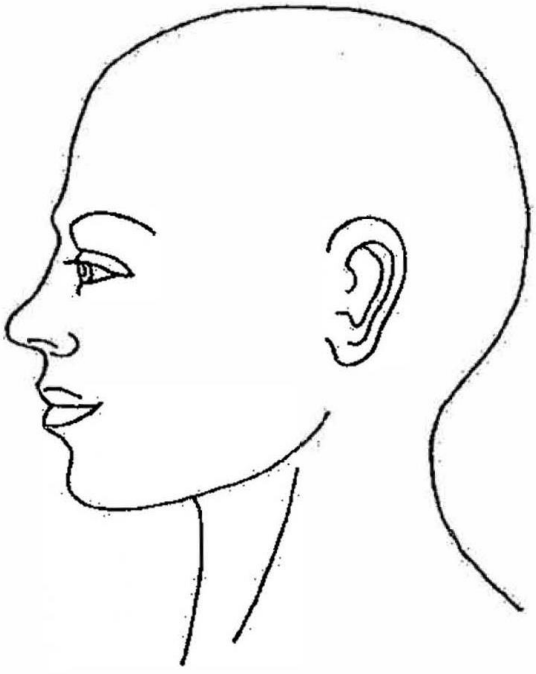

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