Hampshire, Southampton, Portsmouth & IOW

4LSCB Local Safeguarding Children Boards

Bruising in Children who are Not Independently Mobile

A Protocol for Assessment, Management and Referral by Health Practitioners

Aim of protocol

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

It does not reiterate the process to be followed once a referral to Children's Services has been made. For this, practitioners must consult the Pan-Hampshire Safeguarding Children Procedures 2007 published by the Local Safeguarding Children Boards for Hampshire, Isle of Wight, Portsmouth and Southampton (4LSCB): see http://www.4lscb.org.uk/

Target Audience: All front line clinical staff: general practitioners including sessional doctors, locums and GP trainees; primary care staff including practice nurses; health visitors, district nurses, school nurses and midwives; community staff allied to medicine; clinicians in GP out of hours services, walk-in centres, minor injury units and emergency departments; all community and hospital paediatric clinical staff.

Date for Review: January 2011

1. Introduction

1.1 Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews and individual child protection cases across Hampshire 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.

1.2 The recently published NICE guideline When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009) states that bruising in any child not independently mobile should prompt suspicion of maltreatment. See:
http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English .

1.3 In the light of these findings a joint protocol has been developed for health practitioners, for the assessment and management of bruising in children who are not independently mobile and

the process by which such children should be referred to Children's Services and a consultant paediatrician for further assessment and investigation of potential child abuse. The protocol has been approved by the Hampshire, Southampton, Portsmouth & IOW LSCBs.

1.4 In the 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 **all children with bruising who are not independently mobile be referred to Children's Services and for a consultant paediatric opinion.**

2. Definitions

2.1 **Not Independently Mobile**: a child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Includes all children under the age of six months.

2.2 **Bruising**: extravasation of blood in the soft tissues, producing a temporary, non- blanching 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, 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.cf.ac.uk/bruising** .

3.2 Although bruising is not uncommon in older, mobile children, it is rare in infants that are immobile, particularly those under the age of six months. While up to 60% of older children who are walking have bruising, it is found in less than 1% of not independently mobile infants, 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 but rarely on the back, buttocks, abdomen, upper limbs or soft-tissue areas such as cheeks, around the eyes, ears, palms or soles,

3.3 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

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.**

3.5 **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 health professional 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 P 2008). 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 Services, which, if necessary, should be undertaken from the hospital setting. **However it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Services 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 Services

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. The child should then be referred to Children's Services**.

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 domiciliary 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 first professional to learn of or observe 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 Services 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 Services Departments 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 6.1, for a medical opinion before reaching any conclusions on the case.**

6.7 Referral should, in the first instance, be made by phone:

During office hours (8.30am – 5.00pm, Mon – Thurs, 8.30am – 4.30pm, Fridays)

> **Hampshire:** Hantsdirect **0845 6035620** or **01329 225379** (Professionals only – not for members of the public)
>
> **Portsmouth:** Portsmouth Children's Services **023 9283 9111**
>
> **Southampton:** Southampton Children's Services **023 8083 3336**
>
> **Isle of Wight:** IOW Children's Services **01983 525790**

At all other times (including weekends and over Bank Holidays)

> **Hampshire & Portsmouth:** Hampshire Out-of-Hours Service: **0845 6004555**
>
> **Southampton:** Out-of-Hours Service: **023 8023 3344**
>
> **Isle of Wight:** Out-of-Hours Service: **01983 821105**

6.8 All telephone referrals must be followed up within 48 hours with a written referral, using the appropriate Interagency Referral Form and must be fully documented in the patient records.

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

7. Referral For a Paediatric Opinion

7.1 When a child is referred to Children's Services under this protocol, a referral should also be made to the duty paediatric consultant (or associate specialist) 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:

	During office hours	At all other times
Portsmouth:	**023 9247 2948**	**023 9228 6000**
Southampton:	**023 8071 6629**	**023 8079 8465**
Winchester:	**01962 863535**	**01962 863535**
Basingstoke:	**01256 314723**	**01256 473202**
Isle of Wight:	**01983 524081**	**01983 524081**

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 duty paediatric consultant (or associate specialist) must liaise with Children's Services with regard to the outcome of the assessment as soon as it is completed.

7.5 Where a referral is delayed for any reason, or where bruising is no longer visible, a consultant 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 Services, should be explained to the parents or carers frankly and honestly.

8.3 If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children's Services. 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 Services in all cases.

9.2 It is the responsibility of Children's Services 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 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 notify and discuss the findings with the child's health visitor and vice versa.

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 Staff should seek advice or discuss the case with their Area (primary care) or Trust (acute/community trusts) Safeguarding Children's Team but, if unavailable, should not delay referral.

10.6 An individual practitioner 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.

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: Guidance for Practitioners and Managers HM Government 2008*). "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 2006*)

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. 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 identified 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 Services and the paediatrician.

11.6 Where a history of previous child protection concerns is given by Children's Services 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 preferably on a body diagram (Appendix), 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".

11.8 **The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be overemphasised.**

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

Working together to Safeguard Children, HM Government, 2006
http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/

What to Do If You Are Worried a Child Is Being Abused, HM Government, 2006
http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182/

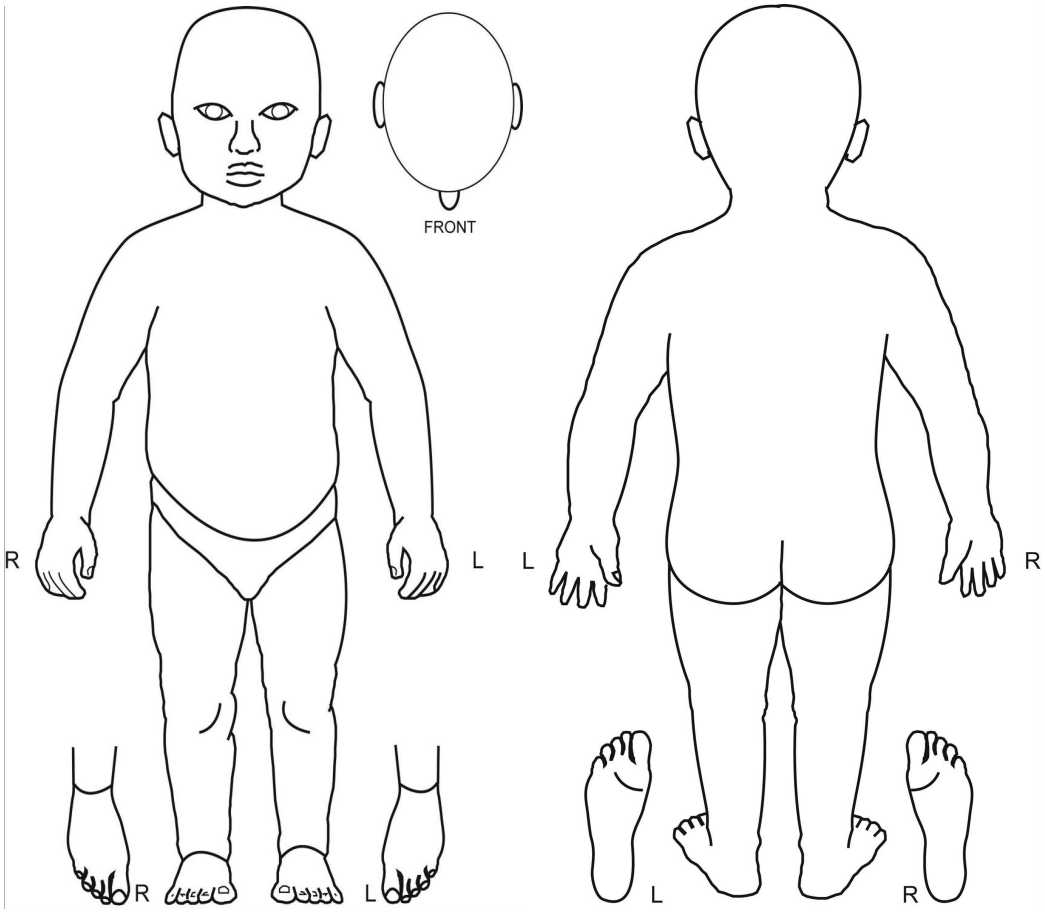
Child Protection Companion, Royal College of Paediatrics & Child Health, April 2006
http://www.rcpch.ac.uk/doc.aspx?id_Resource=1521

When to Suspect Child Maltreatment (NICE Clinical Guideline 89, July 2009)
http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English .

14. Steering Group Members: Dr John Dracass, Named Doctor, NHS Hampshire, Helen Hudson, Named Nurse, Basingstoke Hospital, Dr Simon Jones, Designated Doctor, NHS Hampshire, Lynn Ludford, Hampshire Children's Services, Sue Mitchell, Named Nurse, Hampshire Community Health Care, Karen Newham, Designated Nurse, NHS Hampshire, Debbie Perriment, Hampshire Safeguarding Children's Board. Karen Littlewood, Named Nurse Portsmouth PCT (Co-opted) Dr Jean Price, Designated Doctor Southampton University Hospitals Trust (Co-opted)

Appendix

Skin Map



Key

Child's name:

Date of birth:

Date/time of skin markings/injuries observed:

Who injuries observed by:

Information recorded: **Date:** **Time:**

Name: **Signature:**

Hampshire, Southampton, Portsmouth & IOW Health Community and corresponding Children's Services Departments

Bruising in Children Not Independently Mobile – Protocol Summary

The protocol provides frontline and senior health professionals with a knowledge base and action strategy for the assessment, management and referral of children who are Not Independently Mobile (NIM) who present with bruising or otherwise suspicious marks.

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 before referral to children's Services.

Bruising is the commonest presenting feature of physical abuse in children. The younger the child the greater the risk that bruising is non-accidental. There is a substantial and well-founded research base on the significance of bruising in children. See www.core-info.cf.ac.uk/bruising

Any bruising, or mark that might be bruising, in a child of any age, that is brought to the attention of a health professional should be taken as a matter for inquiry and concern.

Bruising in a child not independently mobile should raise suspicion of maltreatment and should result in an immediate referral to Children's Services and an urgent paediatric opinion.
See NICE Clinical Guideline 89: http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English

Where a decision to refer is made, it is the responsibility of the first professional to learn of or observe the bruising to make the referral.

For Children's Services phone:

	Hampshire	Southampton	Portsmouth	Isle of Wight
Office hours	0845 603 5620	02380 833336	02392 839111	01983 525790
Other times	0845 600 4555	02380 233344	08456 004555	01983 821105

All telephone referrals should be followed up within 48 hours with a written referral using the appropriate interagency referral form.

For a paediatric opinion contact your local acute or community paediatric consultant:

	Southampton	Portsmouth	Winchester	Basingstoke	Isle of Wight
Office hours	02380 716629	02392 472948	01962 863535	01256 314723	01983 524081
Other times	02380 798465	02392 286000	01962 863535	01256 473202	01983 524081

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 by a paediatrician.

Innocent bruising is rare. It is the responsibility of Children's Services and the local acute or community paediatrician to decide whether bruising is consistent with an innocent cause or not.

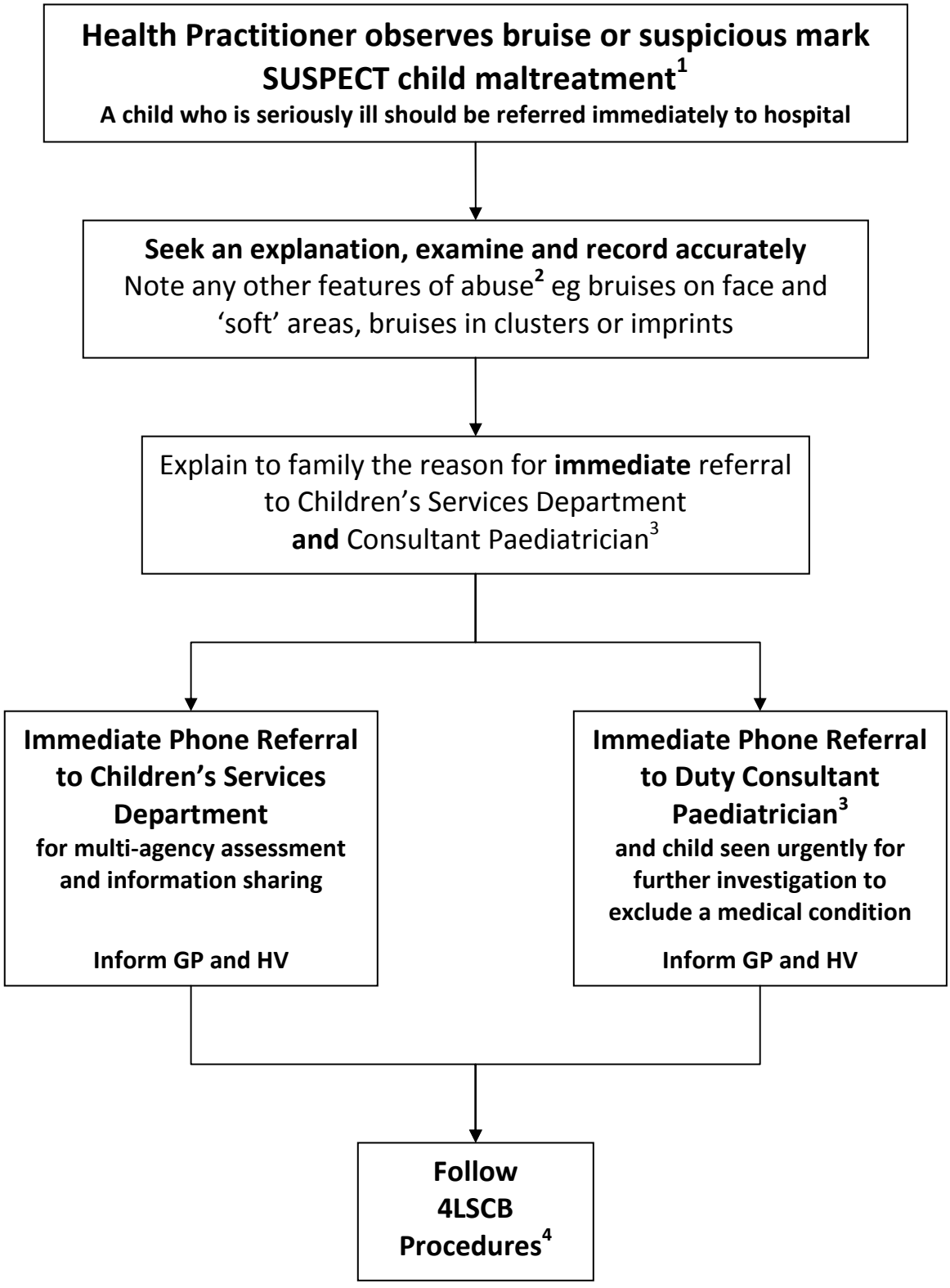
Parents or carers should be included as far as possible in the decision-making process providing this does not pose a further risk to the child. If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children's Services.

Information should be shared between the child's GP and Health Visitor and the case should be discussed with a professional or senior colleague such as the Area Safeguarding Children's Team or the Trust Safeguarding Children's Team.

The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be overemphasised.

Once a referral to Children's Services has been made, practitioners must follow the 4LSCB Safeguarding Children Procedures 2007. See http://www.4lscb.org.uk/

Joint Bruising Protocol for assessment of bruising in a child who is not independently mobile



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)
2. www.core-info.cf.ac.uk/bruising
3. Includes Associate Specialists
4. www.4lscb.org.uk