Gloucestershire Safeguarding Children's Partnership guidance on suspected bruising or injuries, in children who are not independently mobile.

2023

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Gloucestershire Safeguarding Children Partnership

Gloucestershire Safeguarding Children's Partnership (GSCP) guidance on suspected bruising or injuries, in children who are not independently mobile.

Contents

Document Version Table

Version	Date	Comment
Draft v4	09.05.2023	Draft drawn up for consideration
1.0	25th July 2023	QiiP Sign off of the Draft V4 document

This document should be read in conjunction with the chapter on Bruising In Babies and Children in the Gloucestershire Safeguarding Children Partnership Procedures Manual

Please note: If a child appears ill or seriously injured, seek emergency treatment immediately and notify children's social care of your concerns.

Introduction

Bruising is the most common presenting feature of physical abuse in children. It is recognised that the likelihood of a child sustaining accidental injuries increases with increased mobility. Child Practice Safeguarding Reviews (CSPR's) have identified that professionals sometimes fail to recognise the likelihood, for child abuse, from the presence of injuries to non-independently mobile children. Numerous CSPR's have identified situations where children have died because practitioners did not recognise and respond to the significance of what appeared to be minor bruising in a non-mobile infant or child. Children under the age of one are most likely to be killed by their parent or stepparent[1]. Understandably, owing to babies' inability to communicate, abuse tends to be uncovered when there is a critical injury, or when it is too late[2].

Definitions

Professionals: All individuals from all agencies working with children and families either directly or indirectly.

Non-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 as although some children can 'roll over' from a very early age this does not constitute independent mobility. Over six months of age, consideration must be given to the individual child's level of development. This guidance also applies to children with physical disabilities who are not independently mobile.

Injuries: It is recognised that bruising is the most common presentation in children who have been physically abused[3]. However, for the purpose of this protocol, 'injury' will be taken to mean any bruising, unexplained mark, burn, scald, unexplained bleeding, fracture or any other apparent injury to a child. A torn maxillary labial frenulum (lip frenulum) is also a possible indicator of physical abuse. (T*he frenulum is the small piece of tissue that joins the upper lip to the gum*).

Bruising: Leakage of blood into the soft tissues, producing a temporary, non-blanching discolouration of skin, however faint or small, with or without other skin abrasions or marks. This includes petechiae, which are red or purple, non-blanching spots, less than two millimetres in diameter and often appear in clusters. Bruising in very young babies may be caused by medical issues such as birth trauma, although this is very rare. Such trauma should be well documented and the information accessible.

Birthmarks: Birthmarks are irregularities of the skin of congenital origin. They are not always visible at birth and can take several weeks to appear. There are two types of birthmark - vascular and pigmented. Haemangiomas are the most common vascular birthmarks and are seen in one in ten babies, appearing from approximately two weeks post birth. In addition, some medical conditions can cause pigmented marks to the skin that resemble bruises e.g. grey-slate naevi/ blue-grey spots (previously known as Mongolian Blue Spots). These are usually recorded in medical records at birth or the personal child health record (PCHR) but can appear after birth. (See Appendix 1 for further information).

Sentinel Injury: A "sentinel injury" is recognised as a minor injury in a non-mobile child and has been recognised as a precursor to a more significant injury, the most frequent being a bruise[4].

[1] NSPCC, 2020
[2] Ofsted, 2020
[3] Maguire, 2010
[4] RCPCH, 2020

Research Base

The Triennial Analysis of SCR's[5] and four consecutive Biennial Analyses of SCR's[6] have identified that children under the age of 1 year are consistently overrepresented in CSPR's, almost exclusively because of severe injury or death as a result of physical abuse.

It is also recognised that all children with disabilities are at increased risk of abuse. Research suggests that children with disabilities are up to 3.4 times more likely to be abused or neglected than their non-disabled contemporaries[7]. Disabled children are underrepresented in data relating to multi-agency involvement following the identification of potential non-accidental events.

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. Whilst up to 60% of older children who are walking will have bruising on examination, it is found in less than 1% of non-independently mobile infants. Moreover, the pattern, number, and distribution of accidental bruising in non-abused children is different from that in those children who have been abused. Accidental 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 area such as cheeks, around the eyes, ears, palms, or soles. (See Appendix 2 for visual guides).

Patterns of bruising suggestive of physical child abuse include:

- Bruising in children who are not independently mobile.
- Bruising in babies
- Bruises away from bony prominences
- Bruises to the face, abdomen, arms, buttocks, ears, and hands
- Multiple or clustered bruising
- Imprinting or petechiae
- Symmetrical bruising

(RCPCH Child Protection Companion)

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. This is best done as part of a multi-agency strategy discussion.

The younger the child, the greater the risk that bruising is non-accidental and the greater the potential risk of significant or serious harm. Infants under the age of one are more at risk of being killed at the hands of another person, usually a carer, than any other age group of children in England and Wales. Non-mobile babies very rarely cause injuries to themselves and therefore must be considered at significant risk of abuse. Multi-agency information sharing, via a strategy discussion, enables sensible, informed judgements to be made with regard to the child's safety.

Scope of guidance

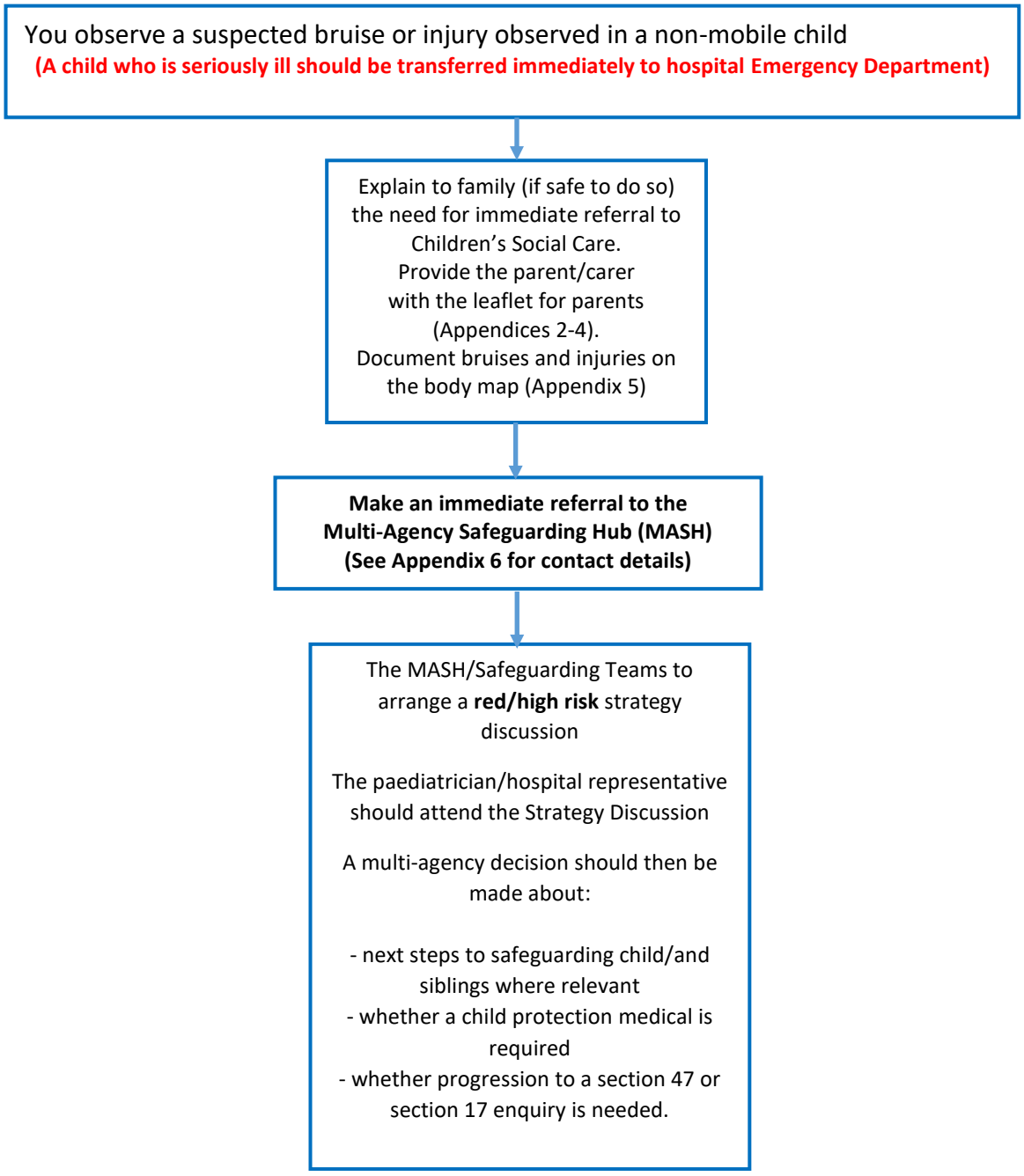
This guidance document, along with the chapter on Bruising In Babies and Children contained in the Gloucestershire Safeguarding Children Partnership Procedures Manual, must be followed in all situations where an actual or suspected bruise or injury is noted in a child who is not independently mobile.

[5] Sidebotham et al, 2016
[6] Brandon et al, 2008 2009 2010 2012
[7] Sullivan and Knutson, 2000

Using professional judgement:

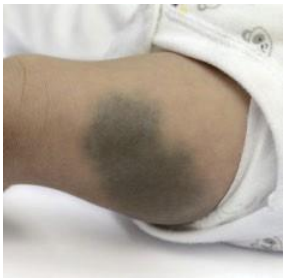
If a suspected bruise or injury in a non-mobile child is observed, a referral must be made to the local Multi-agency Safeguarding Hub (MASH), irrespective of whether the professional feels that there is a low likelihood of a non-accidental cause. **This applies to all professionals including all health professionals.**

Multi-agency pathway for suspected bruising or injuries in children who are not independently mobile:



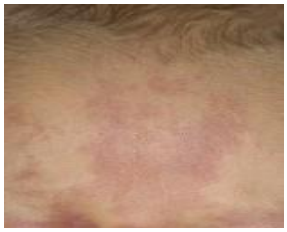
Appendix 1: Bruise or Birthmark?

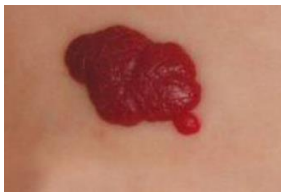
What are birthmarks?
Birthmarks are irregularities of the skin of congenital origin. They are not always visible at birth and can take several weeks to appear. There are two types of birthmarks - vascular and pigmented.

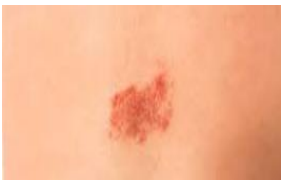


Vascular birthmarks are caused by either abnormal growth of blood vessels or less commonly, by malformation of blood vessels.

Haemangiomas (Commonly referred to as Strawberry Birthmark). These can affect one in ten babies. They normally appear around week two of age. These do occur more in girls, premature babies and multiple births. Haemangiomas may increase in size during the first three months, but it is unusual for them to get bigger after ten months. They then generally settle and then start to shrink in size.







Haemangiomas can also be referred to as capillary haemangioma, infantile haemangioma, naevus simplex, naevus flammeus, stork mark, angel kiss, salmon patch. They often blanch on pressure and can get darker / more visible when a child cries or is warm.

Advice should be given to parents on the nature of the birthmark, the causes and time expected to appear. Some birthmarks will need treatment if they cover the eyes, mouth or nose and should be referred to GP.

Pigmented birthmarks are caused by overgrowth of melanin-producing cells. Like bruises, they do not blanch on pressure. Examples include slate-grey naevi (previously known as Mongolian blue spots), café au lait patches and moles.

Bruises do not blanch on pressure, but vascular birthmarks often do.

Slate-grey naevi often occur on the lower back or buttocks in dark skinned infants, but they can be found on the limbs and elsewhere.

If you see skin changes that might be a birthmark, ask parents to scroll through their photographs. Birthmarks sometimes show up on pictures parents had not realised were there. Always record birth marks (preferably in the personal child health record), even if it is obvious to you what they are. The next practitioner might mistake them for a bruise. Encourage parents to take photographs.

They may not appear for a few days and take up to a few weeks to become visible. They can also occur in white-skinned infants, e.g. if there is Mediterranean ancestry. If a pigmented lesion cannot be distinguished from a bruise and there is no documentation or photographs to show it has been there and unchanged for a period of time, it is sometimes necessary for a safety plan to be agreed between parents and children's social care, whilst the mark is kept under observation by a paediatrician (usually for up to a week).

Appendix 2: Parent Information

Bruising & Injuries in babies and children

Information for parents and carers about bruising or injuries on babies and children who are not independently mobile.

I am worried about an assessment.

We understand that the assessment may be upsetting and that you may feel anxious or worried. We will keep you informed of what is happening and will treat you with courtesy and sensitivity.

If you do not understand any part of the process and need further explanation, then ask the professionals involved who can then provide you with more information.

How can I make a comment about my child's treatment?

The Customer Care Team of the Health Trust where your baby or child's examination is done can help in resolving any concerns you may have. They can provide information and advice and will liaise with other staff and departments to help resolve any problems and concerns as quickly as possible.

Further Information and Support.

Children and Families Front Door Service on 01452 426 565
(Monday to Friday 9am to 5pm)

Out of Hours Emergency Duty Team on 01452 614 758

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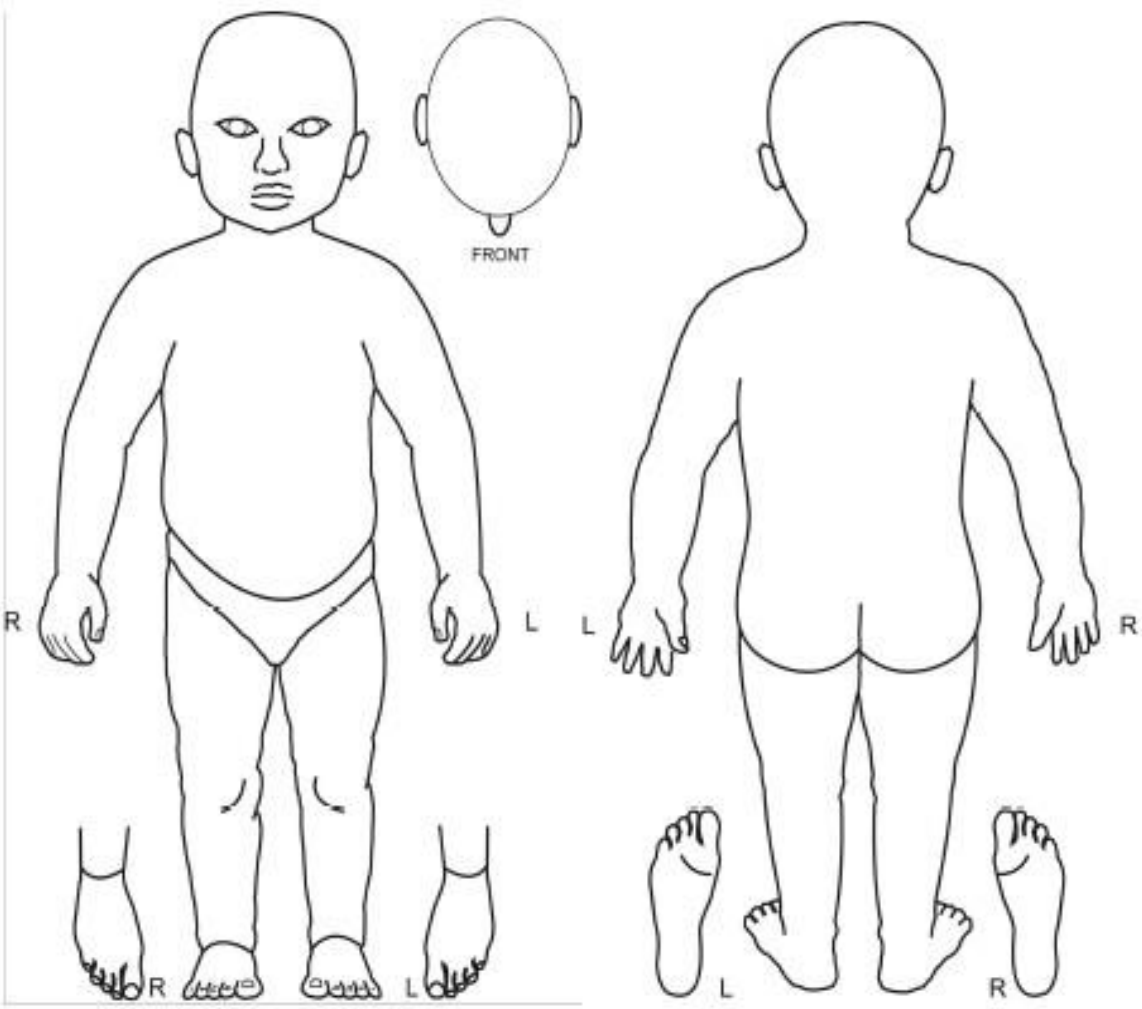
NSPCC 0808 800 5000
www.nspc.org.uk

Family Rights Group 0808 801 0366
www.frg.org.uk

Appendix 3: Body Map



Child's name:

Date of birth:

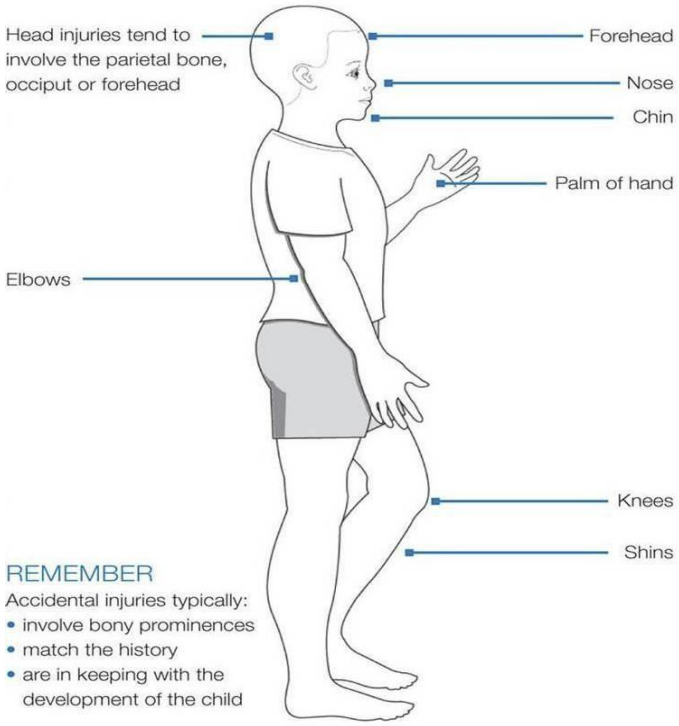
Date/time of skin markings/injuries observed:

Who injuries observed by:

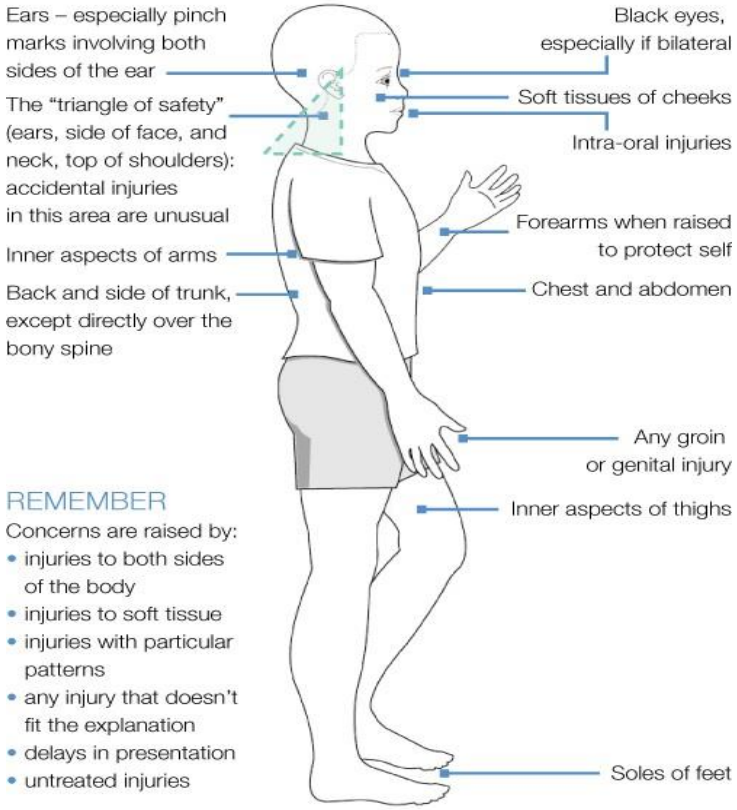
Information recorded: **Date:** **Time:**

Name: **Signature:**

Appendix 4: Typical sites of **accidental** injuries



Appendix 5: Typical sites of **non-accidental** injuries



Appendix 6: Contact and referral details for Children's Social Care:

Working hours team

Children and Families Front Door Service 01452 426565

Monday - Thursday 08.30 - 17:00
Friday: 08.30 - 16:30

Emergency Duty Team

Emergency Duty Team (EDT) on 01452 614194

All Bank Holidays

Weekdays: 17:00 - 08.30

Weekends: 16:30 (Fri) - 08.30 (Mon)

Appendix 7: References

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Royal College of Paediatrics and Child Health (RCPCH) (2017) *Child Protection Evidence- Bruising.* [online]. Available from: https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising.

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Acknowledgements:

Swindon Safeguarding Partnership, Wiltshire Supporting Vulnerable People Partnership, BaNES Safeguarding Partnership