



Bruising in Children Who Are Not Independently Mobile

Multi-Agency Pan Cheshire & Merseyside Guidance for Assessment, Management and Referral by Practitioners

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POLICY/PROCEDURE APPROVAL			
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1. Aim of Guidance:

1.1 The aim of this guidance is to provide front line professionals and senior multi-agency 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 concerning bruise like marks.

“Those who don’t cruise, rarely bruise” N. Sugar 2011

1.2 It does not include nor replace the process to be followed once a referral to Children’s Social Care has been made.

2. Scope:

The target audience for this guidance is all front-line staff working directly with children or their families. This applies to health professionals and allied non-health agencies, such as Children’s Social Care, Police and education/nurseries.

3. Introduction:

3.1 Bruising is the commonest presenting feature of physical abuse in children and must not be ignored. Learning from child protection cases indicates that the presence of bruising in children who are not independently mobile is highly predictive for further child abuse. There are several cases in which a child with bruising (sentinel injury) has later suffered significant harm that might have been prevented if action had been taken at the time of the earlier injury.

3.2 This document doesn’t encompass other injuries, but the expectation is for professionals to consider the same principles and to have a high level of suspicion and low threshold for referral to Children’s Social Care.

3.3 The NICE Guideline (NG76) October 2017 “When to Suspect Child Maltreatment” states that bruising in any child not independently mobile should prompt suspicion of maltreatment.

<https://www.nice.org.uk/guidance/ng76/chapter/Recommendations>

3.4 Considering the above learning and guidance, this guidance has been developed for 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 Social Care.

3.5 This guidance recognises that professional judgement and responsibility must be exercised at all times. However, it errs on the side of safety by

requiring that **the majority of children not independently mobile who present with bruising should be discussed with social care as a minimum**, to inform decision making and next steps. There is an expectation that most cases will result in a referral to Children's Social Care.

- 3.6 Referral to Children's Social Care enables a multiagency discussion to consider the need for a child protection medical assessment by a specialist paediatrician, facilitating a medical opinion regarding the likelihood or not of abuse.
- 3.7 Professionals must always have a degree of suspicion when a child is injured and no explanation is offered, the explanation does not appear plausible, explanations change or there is a delay in presentation. If the child is not independently mobile and/or non-verbal, and has a bruise, the level of suspicion must be higher.
- 3.8 It is not always easy to differentiate with certainty if a bruise like mark is a bruise or birth mark.
- 3.9 Independent mobility is not age dependant and includes those children who are older but have limited mobility due to a medical condition or disability.
- 3.10 It is the responsibility of Children's Social Care, in conjunction with the local/designated paediatric department and Police, to decide whether the circumstances of the case and the explanation for the injury are consistent with an accidental cause, medical explanation or inflicted injury. This would usually be as part of a strategy discussion or a strategy meeting prior to and/or after the child protection medical assessment.

4. Definitions:

- 4.1 **Not Independently Mobile (non-mobile children):** this includes babies or children who have not reached the developmental stage of rolling, crawling, shuffling, pulling to stand, cruising or walking independently. Not independently mobile children also include those children who are older but have limited mobility due to a medical condition or disability.

Caution needs to be applied if a child is non-verbal, as they cannot provide their own separate explanation for a bruise.

- 4.2 **Bruising** is the extravasation of blood in the soft tissues, producing a temporary, non-blanching discolouration of skin, however, faint or small, with or without associated injuries e.g. abrasions. The colouring of a bruise

is wide ranging and is reliant on the observer. There is no set timing or sequence for the colour of a bruise making it almost impossible to age a bruise. Causes include blunt force trauma, prolonged straining, some medications or specific medical conditions e.g. infection, vasculitis, bleeding disorders.

4.3 **Petechiae** are red or purple tiny less than two millimetres non-blanching spots, often in clusters, as a result of damage to capillaries or smaller blood vessels.

4.4 **Birthmarks** are a congenital, mainly benign, irregularity on the skin which is present at birth and is apparent shortly after birth and usually by a month. Birthmarks can occur anywhere on the skin and are caused by overgrowth of any or all of blood vessels, melanocytes, smooth muscle, fat, fibroblasts, or keratinocytes. They are usually brown, pink, red or purplish colour or in the case of blue/grey spots (Congenital dermal melanocytosis previously known as Mongolian blue spots), a diffuse blue/grey colour. If there is any uncertainty about the cause of any of these marks, then advice should be sought. See Appendix A: Guidance on Managing Babies with Suspected Birth Marks including Blue/Grey Spots, and other birth marks.

5. Guidance for All Professionals If They Have Concern Regarding Bruising in Babies or Non-Mobile Child:

5.1 Any bruising in a non-mobile child, regardless of age, must raise a suspicion of a non-accidental injury.

5.2 Please note where a bruise or injury has been seen by a professional but cannot now be seen, this same procedure should be followed to initiate a referral to Children's Social Care.

5.3 **All professionals who have a concern about a possible bruise sustained by a non-mobile child have a duty to make a referral to social care.**

5.4 If there are concerns around a possible bruise identified by a professional, this should be referred to social care in the first instance **and not referred to the GP/primary care practitioner.**

5.5 It is a safeguarding risk for professionals without appropriate expertise and experience to diagnose "accidental bruising" in non-mobile children. Specialist review and investigations are often required by a safeguarding paediatrician.

- 5.6 For a non-health practitioner advice must be sought from their manager/designated safeguarding lead within their organisation.
- 5.7 A referral to Children's Social Care must not be delayed if timely advice is not available from a colleague.

6. Clinical Assessment / Determination of the Significance of Bruising in Babies or Non-Mobile Child:

- 6.1 Accidental bruising is common in older mobile children, up to 60% of older children who are walking have bruising. However, it is rare in infants that are immobile, particularly those under the age of six months and is found in less than 1% of not independently mobile infants. The risk is much higher in infants who are not yet rolling.
- 6.2 The pattern, number and distribution of innocent bruising in non-abused children maybe different to that in those who have been abused. Accidental bruises in mobile children are more commonly found over bony prominences and on the front of the body, much less frequently on the back, buttocks, abdomen, upper limbs or soft-tissue areas such as cheeks, around the eyes, ears, palms or soles. Patterns of bruising that should raise concern include multiple or clustered bruising, imprinting and petechiae within bruising (petechiae alone can be due to a medical cause, or inflicted e.g. suffocation), symmetrical bruising and bruising in genital areas, that also raises the possibility of sexual abuse.
- 6.3 It is unusual but not unknown for siblings to injure a baby/child. In these circumstances, the child must still be referred to Children's Social Care to facilitate a detailed history of the circumstances of the injury, and consideration of the parents' ability to supervise their children.
- 6.4 **The younger the child the greater the risk that bruising is non-accidental and the greater potential risk to the child.**

7. Health Practitioner:

- 7.1 In primary care practitioners may discuss concerns with their safeguarding lead or Named GP for advice, provided this is timely and causes no undue delay in referral. The local safeguarding team, including the Named GP, can be contacted on merseysideicbsafeguarding@cheshireandmerseyside.nhs.uk or cheshireicbsafeguarding@cheshireandmerseyside.nhs.uk but this is not to be used for an urgent response. Concerns must also be notified to the child's health visitor/school nurse if applicable and vice versa, to share information.

- 7.2 In the general practice out of hours service such a discussion must take place either with the clinical director of the service, with a senior colleague or if not available the paediatrician on call. The family GP must be informed of the discussion and the outcome. The local safeguarding team including Named GP for safeguarding can be contacted in hours if concerns or escalation is required via merseysideicbsafeguarding@cheshireandmerseyside.nhs.uk or cheshireicbsafeguarding@cheshireandmerseyside.nhs.uk
- 7.3 **The importance of signed, timed, dated, accurate, factual, and contemporaneous records cannot be over emphasised.** In all cases careful mapping, description and recording of the size, colour characteristics, site, pattern and number of the bruises must be made preferably on a body diagram (appendix B), and a careful verbatim record of the carers/parents' description of events and explanation for the bruising made in the clinical notes.
- 7.4 In the hospital emergency department, clinic or ward, the discussion must be with the most senior clinical colleague available.
- 7.5 Health staff can also seek advice or discuss the case with their own Safeguarding Children Team. If unavailable, they must be informed of concerns / referral as soon as possible.
- 7.6 An individual practitioner must not be afraid to challenge the opinion, or decision making, of a colleague if they believe in their own judgement that a child might be at risk of harm. Any disputes must follow the local internal escalation policy and/or Local Authority Safeguarding Partnership escalation if relevant.
- 7.7 If the case raises any suspicion, and the case is not referred to social care, the findings must be shared and discussed with another professional or senior colleague and the safeguarding children lead. This may lead to a referral to social care. If a referral is not required the discussion and rationale for this should be documented by the professional. Even if an explanation is plausible/credible a referral may be needed if this is a result of accidental injury which may question level of parental support or supervision. Support through a referral to Early Help may then be appropriate.
- 7.8 Practitioners must take into consideration cultural practices and racial characteristics when assessing bruising, including communication difficulties. However no cultural practice should harm a child. Family members should not be used to translate.
- 7.9 The referral should also include a review of the child's medical history, including any previous occurrence of bruising or injury. Other relevant family health

records may need to be reviewed. Consideration must be given to identify vulnerabilities within the family such as domestic abuse, substance misuse, and mental health issues.

- 7.10 Where a history of previous child protection concerns is given by Children's Social Care this information must be recorded in all the health records relating to the child.

8 Medical Needs First / Emergency Admission to Hospital:

- 8.1 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 for management of medical needs first. Practitioner to confirm child attends hospital if not taken via ambulance.
- 8.2 Addressing medical needs should not be delayed by a referral to Children's Social Care, 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 Social Care has been made and concerns shared with the paediatrician on call for safeguarding.**
- 8.3 Of note children may be abused (including sustaining fractures, serious head injuries and intra-abdominal injuries) with no evidence of bruising or external injury.

9 Involving Parents or Carers:

- 9.1 The decision to refer to Children's Social Care and/or a paediatrician should be explained clearly, frankly and honestly with consideration of professional transparency.
- 9.2 In the interest of duty of candour, whenever possible, parents / carers should be included in the decision-making process, unless it poses a further risk to the child or to do so would jeopardise information gathering.
- 9.3 Professionals should explain to carers at an early stage why the bruising or bruise like marks cause concern, particularly in not independently mobile children, and discuss the need for further questioning and examination by "a specialist" paediatrician. Consider if interpreter/additional support for parent is required, to facilitate understanding.

- 9.4 Professionals should **inform** the carer/parent of the referral unless the practitioner feels this would place the child at risk of further harm. The carer/parent does not need to consent, and lack of consent must be overridden in the best interest of the child as the “welfare of the child is paramount”.
- 9.5 If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children’s Social Care CSC, and a place of safety / safety plan mutually agreed.

10 Referral to Children’s Social Care:

- 10.1 If a referral to social care is not made, the reason must be justified and documented, with detail of the names of the professionals making this decision. Referral to Social Care enables a multiagency discussion regarding the need for a child protection medical assessment by a specialist paediatrician, facilitating a medical opinion regarding the likelihood or not of abuse.
- 10.2 When a referral to social care is necessary, it is the responsibility of the first professional who was made aware of or observed the bruising to make the referral in line with Safeguarding Procedures including own organisation’s procedures with immediate telephone referral.
- 10.3 Referrer to provide information about the child and social history, if known. An immediate interim safety plan for child and siblings needs to be considered by Social Care in conjunction with the referrer.
- 10.4 Referral should, in the first instance, be made by phone. A safety plan (which may include consideration of a place of safety), pending contact by social care with the child must be mutually agreed between referrer and social worker. Ideally before the referrer leaves the clinical setting or home, if in community setting.
- 10.5 If a child has sustained an injury and concerns include individuals working with children, consideration should be given for referral to Local Authority Designated Officer.
- 10.6 All telephone social care referrals must be followed up with completion of a Multi-Agency Referral form for Children’s Social Care within 24 working hours (may vary as per Local Authority policy.)
- 10.7 The referrer will receive an update of the outcome of the referral within 24 working hours. If no update is provided the referrer should request an update.

If there are any issues regarding the feedback that cannot be resolved with the appropriate CSC Team then the referrer should follow the SCP escalation policy located on the SCP website.

- 10.8 As discussed whenever possible, the child's parent or carer must 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 and accounting for General Data Protection Regulation (GDPR) "Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers July 2018". 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 2023*).

11 Child Protection Medical:

- 11.1 Children's Social Care should discuss children with the on-call consultant for safeguarding/relevant local clinician to determine if a child protection medical is required.**
- 11.2 A bruise must never be interpreted in isolation. Bruising must always be assessed in the context of medical and social history, developmental stage and explanation given.
- 11.3 Where a bruise is noted, there needs to be a mechanism of trauma to explain the damage to the blood vessels, resulting in bruising. Most bruising is due to trauma, usually blunt force trauma or occasionally suction trauma. A cautionary note: lying on a surface or object, even prolonged, is not sufficient to cause trauma so it cannot always be accepted as a valid explanation for a bruise.
- 11.4 In a few cases bruising may be associated with an underlying medical condition e.g., infection, haematological condition, vasculitis or connective tissue disorder. The opinion and differential diagnosis are the responsibility of an appropriately experienced doctor.
- 11.5 A review of the child's medical history, including any previous occurrence of bruising or injury and any increased bruising or bleeding tendency should be undertaken.
- 11.6 A paediatrician who has the appropriate expertise to assess the nature and presentation of the bruise should undertake a full physical examination of

the completely undressed child. This should include weighing, observation of general demeanour, interaction with carer / parent, cleanliness, infestations, nourishment and body proportion, developmental stage of the child as well as looking for other bruising or evidence of injury. If available, the child's growth chart should be examined.

- 11.7 Colour of the bruise cannot be used to accurately time the bruising.
- 11.8 A strong plausible and credible explanation for the bruising must 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, with responses documented verbatim. 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. There must be consideration of other siblings who may also be at risk of harm.
- 11.9 The lack of a consistent explanation or an explanation that is incompatible with the appearance or circumstances of the findings or with the child's age or stage of development should raise suspicion of abuse.
- 11.10 If a child safeguarding medical examination takes place under child protection procedures the relevant hospital documentation must be completed.
- 11.11 A multi-agency strategy meeting including police, health, social care and education, to consider any other information on the child and family and any known risks, and jointly decide whether any further assessment, investigation is required to support the family or protect the child. This discussion should always include the health professional who reviewed the child or appropriate senior colleague.
- 11.12 Only then can a conclusion be reached as to whether or not an explanation offered is plausible and credible.

Appendix A:

Guidance on Managing Babies with Suspected Birth Marks including Blue/Grey Spots, and other birth marks.

- a.1 The aim of this guidance is to reduce the number of inappropriate referrals to child protection processes, whilst ensuring genuine bruising is not overlooked.
- a.2 Bruising in non-mobile children is rare but significant as it may indicate abuse or neglect. However, birth marks are relatively common, especially blue/grey Spots (Congenital Dermal Melanocytosis, previously known as Mongolian blue spots), and can mimic bruising.
- a.3 Since most (but not all) birth marks, such as blue/grey Spots, are present from birth, when present it is crucial to document them as soon as possible to ensure information is shared and available at future health practitioner consultations. Documentation includes lesions described and drawn on a body map, with a note made of the site, size, colour and appearance and allows further examiners to compare their findings with previous observations. This can be done by the midwife, GP, paediatrician or health visitor, and part of the discharge notification/NIPE to GP, community midwife and health visitor. When marks are first noted in the community, the same details should be recorded in the maternity record, the child health record (red book) or the health visiting records. It is important that GPs complete the relevant documents as part of the 6-8 week check and record whether or not birth marks are present, including in the Parent Held Red Book, when available. This provides an assessment at a particular point in time.
- a.4 Blue/grey spots are a form of birth mark. They are rare in white European children but very common in children of African, Middle Eastern, Asian or Mediterranean ethnicity including those of descent. Although the birthmark is congenital it may not be visible at birth but become apparent some weeks later; parents may not have noticed the mark before the professional.
- a.5 Blue/grey spots can be single or multiple marks, vary in size from few centimetres to extensive. They can be present anywhere on the body; common on buttocks, lower back, occasionally on limbs but rarely on head or face. They are flat and predominantly a uniform colour ranging from light grey to very dark blue. Unlike a resolving bruise there is no variation of colour over days with no other signs sometimes associated with

bruising such as tenderness and swelling. Blue/grey spots fade with time and are usually not visible after a number of years.

a.6 It is important that should a health professional identify birth marks that they are recorded in the “red book” ideally with a body map. See body map below.

a.7 What are Blue/Grey Spots?

- Areas of skin hyperpigmentation – flat, not raised, swollen or inflamed.
- Not painful to touch.
- Usually present at birth but can develop some weeks later.
- Will not change in shape or colour within a few days.
- Normally uniform blue/grey in colour across the mark.
- Common in African, Middle Eastern, Mediterranean, Asian children and those of mixed ethnicity.
- Whilst most occur at the lower back and buttocks, they can appear anywhere (e.g. back of shoulder or limb). Scalp/face rarely affected.
- Can be single or multiple and vary in size.
- Gradually fade over many years.
- Do not require treatment.

a.8 What is a Strawberry Nevus?

A strawberry nevus is a form of ‘birthmark’ that is often not present at birth. It may appear anywhere on the body. Over the first few weeks of life, it can initially appear as a small, flat red mark though with time can develop into a raised red lesion. A strawberry nevus usually flattens and reduces in size by 5-6 years of age. A strawberry nevus occasionally requires treatment by a specialist paediatric surgeon. If near the eye it can have a longterm effect on the child’s vision and requires a referral for an ophthalmology assessment. Whilst an experienced clinician may be confident in the diagnosis without further action, when flat it and can be difficult for a less experienced practitioner to distinguish a strawberry nevus from bruising. If the practitioner is uncertain, specialist / senior advice should be sought.

a.9 Marks Related to Delivery

It is common for babies to have findings on the skin usually noted immediately after delivery, including bruises, abrasions and swellings, particularly over the scalp area. In the case of new-born infants where bruising may be the result of birth trauma or instrumental delivery, professionals must still remain alert to the possibility of physical abuse, even in a hospital setting. In this situation clinicians

should consider the birth history, the degree and continuity of professional supervision and the timing and characteristics of the bruising before coming to any conclusion. Marks should correlate with the delivery history. It is particularly important that accurate details of any birth related bruising should be communicated to the infant's general practitioner, health visitor and community midwife. Where practitioners are uncertain whether bruising is the result of birth injury, they could contact midwifery team/safeguarding midwife for birth information. If any concern remains the professional should immediately seek advice from the duty senior safeguarding paediatrician. All marks related to delivery are present from birth and most settle over the first 2 - 3 weeks of life. It is crucial to document them in the maternity record and when available the baby's red book and as soon as possible. The lesions should be drawn on a body map, and a note made of the site, size, colour and appearance and allows further examiners to compare their findings with previous observations. The midwife who has visited the baby after birth will be aware of these marks.

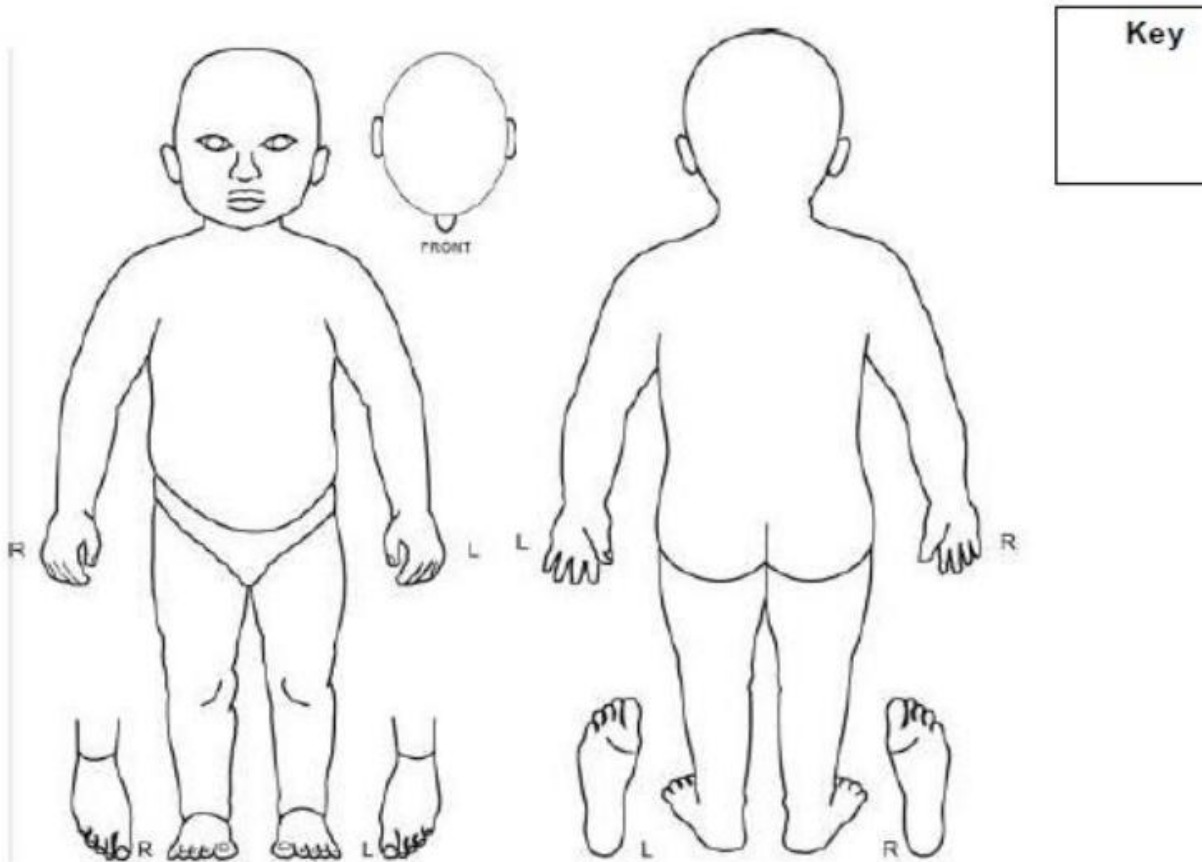
- Forceps marks: appear as linear/patterned bruises over one or both cheeks.
- Ventouse marks: large circular marks over the scalp; there may be associated swelling.
- Fetal blood sampling / fetal scalp electrode: small circular 'punched out' breaks to the skin over the baby's scalp from monitoring baby's condition prior to delivery.
- Cephalhaematoma: boggy swelling over one or both sides of the scalp, limited to the scalp attachment/suture lines. It can occur in any type of vaginal delivery. Sometimes the swelling can 'calcify' – i.e. it becomes firmer over time and stay as a rounded hard lump over one or both parietal areas at the back of the head. Cephalohaematomas can take several weeks to resolve.

a.10 Arranging a Further Opinion

Contact GP surgery first to request same day review of the baby. If this is not possible or if the GP is not confident to give a further opinion, then contact the paediatrician on call for general paediatrics, who can consider a medical review and liaise with the paediatrician on call for child protection if required.

Appendix B:

Body Map



Child's name:

Date of birth:

Date/time of skin markings/injuries observed:

Injuries first observed by:

Information recorded by:

Date:

Time:

Name:

Signature: