Bruising in Children who are Not Independently Mobile

Multi-Agency Pan Cheshire & Merseyside Guidance for Assessment, Management and Referral by Practitioners Jan 23

Aim of Guidance:

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 marks.

"Those who don't cruise, rarely bruise" N. Sugar 2011

It does not include nor replace the process to be followed once a referral to Children's Social Care has been made. Referrals and Enquiries

Scope:

The target audience for this guidance is all front-line staff working directly with children. This list is not comprehensive but includes including: all community and hospital paediatric clinical staff, general practitioners, sessional doctors, locums, GP trainees, primary care staff including practice nurses, health visitors, district nurses, school health advisers and midwives, community staff allied to medicine, clinicians in GP out of hours services, urgent care centres, minor injury units and emergency departments, dentists, pharmacists and North West Ambulance Service (NWAS). It also applies to allied non-health agencies, such as Children's Social Care, Police and education/nurseries.

This guidance must be read in conjunction with St Helens Safeguarding Partnership procedures: Welcome to the St. Helens Multi-Agency Procedures Manual

It is the responsibility of Children's Social Care, in conjunction with the local paediatric department and Police, to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not. This would usually be as part of a strategy discussion or a strategy meeting prior to and/or after the child protection medical assessment.

1 Definitions

1.1 **Not Independently Mobile (non-mobile children):** this includes those 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.

1.2 **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.

1.3 **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.

1.4 **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. They can occur anywhere on the skin. Birthmarks 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 (previously known as Mongolian blue spots), a diffuse blue/grey colour.

1.5 **See Appendix A:** “Guidance on Managing Babies with Suspected Birth Marks, including Blue/Grey Spots and other “innocent skin marks”.

If there is any uncertainty about the cause of any of these marks then advice should be sought.

2 Introduction

2.1 **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.

2.2 NICE Guideline states that bruising in any child not independently mobile should prompt suspicion of maltreatment.

Recommendations | Child abuse and neglect | Guidance | NICE

Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE

2.3 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 Service.

2.4 This guidance recognises that professional judgement and responsibility have to 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.

2.5 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.

2.6 Professionals must always have a degree of suspicion when a child is injured and no explanation is offered, 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.

2.7 It is not always easy to differentiate with certainty if a skin mark is a bruise or birth mark.

2.8 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 Research base

3.1 There is a substantial and well-founded research base on the significance of bruising in children. Child Protection Evidence Systematic Review on Bruising : https://childprotection.rcpch.ac.uk/child-protection-evidence/bruising-systematic-review/

3.2 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.

3.3 **The Child Safeguarding Practice Review Panel (September 2022):** 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. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1106085/14.155_DFE_Child_safeguarding_Bruising_PB1_v3_Final_PDFA.pdf

3.4 The pattern, number and distribution of innocent bruising in non-abused children maybe different to that in those who have been abused. Innocent 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.

3.5 Patterns of bruising that should raise concern of suggestive of physical 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 within bruising (petechiae alone can be due to a medical cause, or inflicted e.g. suffocation)

- symmetrical bruising
- bruising in intimate areas, that also raises the possibility of sexual abuse

3.6 The younger the child the greater the risk that bruising is non-accidental and the greater potential risk to the child.

4. Clinical assessment / determination of the significance of bruising:

4.1 A bruise must never be interpreted in isolation. Bruising requires 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. Only then can a conclusion be reached as to whether or not an explanation offered is plausible and credible.

4.2 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.

4.3 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. **If a medical cause is suspected advice should be sought from the local paediatrician on call for safeguarding.**

4.4 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.

4.5 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.

4.6 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.

4.7 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. A multi-agency discussion 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. **In most instances it is expected that this will result in a formal referral to Children's Social Care**.

5. Initial practitioner decision: is the bruising significant?

5.1 Consult Appendix A: birth marks and other innocent marks to consider differential diagnoses. In addition to clinical assessment the following may also assist:

5.2 Features indicating an increased risk that bruising is due to abuse rather than to accidental or medical reasons:

- Bruising on the head especially the face, ears and neck, abdomen, upper limbs (especially arms and hands), back, buttocks and around the anus or genitals
- Bruises in clusters
- Large bruises
- Bruising on soft tissues (away from bony prominences)
- Multiple bruising especially of uniform shape or symmetrical positions
- Imprints and patterns e.g., 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.
- Bruising with associated petechiae
- Boggy forehead swelling with peri-orbital oedema (violent pulling of the child's hair, head butt)

- Accompanying injuries such as scars, scratches, abrasions, burns or scalds
- Bruising in non-mobile children and / or bruising in disabled children

5.2 **Features more commonly associated with innocent bruising:**

- Shins and the knees in mobile children
- Back of the head, the front of the face, including the forehead, the nose, upper lip and chin as a result of trips and falls
- Bruising to the forehead in children who are pulling to stand

However, these features may also occur in abused children and it is important to re-emphasise that any bruising in a child not independently mobile is unusual: **"those who don't cruise rarely bruise".**

A small percentage of bruising in children not independently mobile will have an innocent explanation or medical cause.

Innocent bruising, medical causes and non-accidental injury are not mutually exclusive.

6. <u>Sharing information and consulting colleagues</u>

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

6.2 A referral to social care must not be delayed if timely advice is not available from a colleague.

6.3 Child protection issues are necessarily complex and seeking advice from a colleague to protect against professional optimism and promotes safe practice.

6.4 Because of the difficulty in excluding non-accidental injury, practitioners should seek advice from Children's Social Care in cases without an obvious innocent explanation, to establish if the child and/or family are already known to services in respect of any ongoing or previous concerns. However, this must not influence a decision to refer if there are initial concerns.

6.5 Colour of the bruise cannot be used to accurately time the bruising.

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

6.7 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.

6.8 For a non-health practitioner advice must be sought from a health practitioner with sufficient experience and expertise to assist in the further management of the child.

6.9 In primary care a general practitioner may discuss concerns with their safeguarding lead or Named GP for advice, provided this is timely and causes no undue delay in referral. Concerns must also be notified to the child's health visitor and vice versa.

6.10 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 named GP for safeguarding and the family GP must be informed of the discussion.

6.11 In the hospital emergency department, clinic or ward, the discussion must be with the most senior clinical colleague available.

6.12 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.

6.13 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. Any disputes must follow the local escalation policy.

6.14 The referral to Children's Social Care, to inform the paediatrician undertaking the safeguarding, must include all information known at presentation and include a body map of findings. This will assist in the final interpretation of a finding and opinion of whether the findings are non-accidental or accidental injury or innocent marks.

6.15 Practitioners must take into consideration cultural practices and racial characteristics when assessing bruising, including communication difficulties. However no cultural practice should harm a child.

6.16 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 and deliberate self-harm.

6.17 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.

6.18 It is unlikely that all the above information will be available to the referrer when initial concerns arise but will assist in provision of an expert opinion.

6.19 **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. GP records must be flagged as "at risk" if concerns remain.

6.20 If a child safeguarding medical examination takes place under child protection procedures the relevant hospital documentation must be completed.

7. Medical needs first / emergency admission to hospital

7.1 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.

7.2 Such a referral 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.**

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

8. Involving Parents or Carers

8.1 The decision to refer to Children's Social Care and a paediatrician should be explained clearly, frankly and honestly with consideration of professional transparency.

8.2 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.

8.3 Professionals should explain to carers at an early stage why the bruising or marks cause concern, particularly in not independently mobile children, and discuss the need for further questioning and examination by "a specialist" paediatrician.

8.4 Professionals should **inform** the carer/parent of the referral. Whenever possible consent should be sought for the referral unless the practitioner feels this would place the child at risk of further harm. However, 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".

8.5 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.

9 Referral to Children's Social Care

9.1 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 for urgent cases. Are you a professional who has concerns for a child or young person? - St Helens Borough Council

9.2 If a referral to social care is not made, the reason must be justified and documented, with detail of the names of the professionals taking this decision.

9.3 Referral should, in the first instance, be made by phone. A place of safety pending contact by social care with the child must be mutually agreed between referrer and social worker.

For St Helens, advice about Child Protection matters contact the Contact Centre on 01744 676767 option 2 during office hours or EDT outside working hours on 0345 050 0148.

9.4 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. CYPS Service Request - St Helens Borough Council

9.4 The referrer will receive an update of the outcome of the referral. If no update provided the referrer should request an update. If there are any issues regarding the feedback that cannot be resolved with the MASH CSC Team Manager or MASH Coordinator then the referrer should follow the SCP escalation policy located on the SCP website.

9.5 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 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 2018*).

10 Conclusion

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 less mobile the child the greater the risk that bruising is non-accidental.

"Those who don't cruise rarely bruise".

10.1 It is important that a plausible and credible explanation for the bruising/finding should be sought at an early stage from parents or carers and recorded. Enquiry regarding explanation

must be with open questioning (not leading questions) in transparent manner with parents /carers.

10.2 The lack of a consistent explanation or an explanation that is incompatible with the appearance or circumstances of the mark within the child's age or stage of development should raise suspicions of abuse and the usual child protection procedures must be followed.

10.3 The child's medical records, including general practice, any history of bruising must be flagged as a significant problem/risk factor in the notes.

11 Further Reading / Guidance

11.1. Further guidance can be found in the policy Child Protection Enquiries

11.2. RCPCH Systematic Review on Bruising: https://childprotection.rcpch.ac.uk/child-protection-evidence/bruising-systematic-review/

11.3. Working Together to Safeguard Children, HM Government 2023

11.4. What to Do If You Are Worried a Child Is Being Abused, HM Government, 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf

11.5. Child Protection Companion, Royal College of Paediatrics & Child Health, on line resources https://www.rcpch.ac.uk/resources/child-protection-companion-about

11.6. Child maltreatment: when to suspect maltreatment in under 18s (NICE Clinical Guideline 89, Oct 2017) https://www.nice.org.uk/guidance/cg89

11.7. CG 89- When to Suspect Child Maltreatment (December 2009; updated 2017); National Institute of Health and Clinical Excellence.

11.8. NG76- Child Abuse and Neglect guideline (October 2017); National Institute of Health and Clinical Excellence.

11.9. Bruising – A systematic review (September 2010) Welsh Child Protection Systematic Review Group. http://www.core-info.cf.ac.uk/bruising/index.html

11.10. The Child Safeguarding Practice Review Panel – Bruising in Non-mobile Infants

Appendix A

Guidance on Managing Babies with Suspected Birth Marks including Blue/Grey Spots, and other "Innocent Skin Marks".

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.

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 (previously known as Mongolian blue spots), and can mimic bruising.

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 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.

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.

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.

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.**

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. 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 long term 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.

b. 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, healthy visitor and community midwife. Where practitioners are uncertain whether bruising is the result of birth injury they 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.

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 child protection, who can liaise with the paediatrician on call for a medical review if it is still a possible innocent/birth mark.

Innocent Bruising / mark

Rarely, bruising in children who are not independently mobile may have an innocent explanation such as an underlying medical condition. Nevertheless because of the difficulty in excluding non-accidental injury, practitioners should seek advice from Children's Social Care in all cases to establish if the child and/or family are known to services in respect of any ongoing or previous concerns, though this should not influence initial concerns. Advice may also be sought from a consultant paediatrician and from Children's Social Care in all cases. It is a safeguarding risk for professionals to diagnose innocent bruising, without significant expertise and if required timely access to investigations.

c. 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.**

d. Practitioners must take into consideration cultural practices and racial characteristics when assessing bruising, including communication difficulties. However no cultural practice should harm a child.

e. Where a history of previous child protection concerns is given by Children's Social Care, this information must be recorded in the health record.

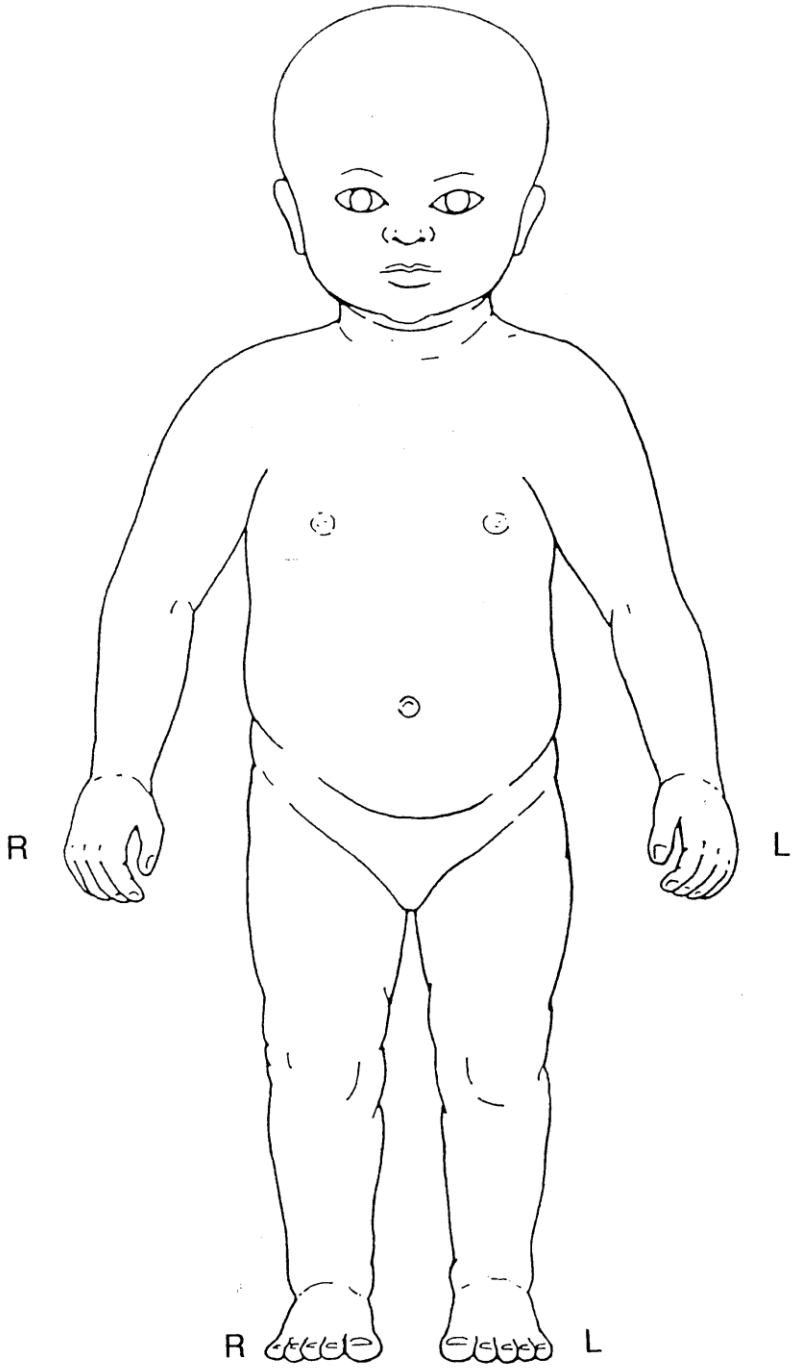
An individual practitioner must not be afraid to challenge the opinion of a colleague if they believe in their own judgement that a child might be at risk of harm. Any professional can invoke the local escalation policy:

APPENDIX B:

Name: d.o.b NHS No:

Date / time of documentation: Documentation by: *print name*
signature

Other comments *(e.g date marks first noted, by whom)*



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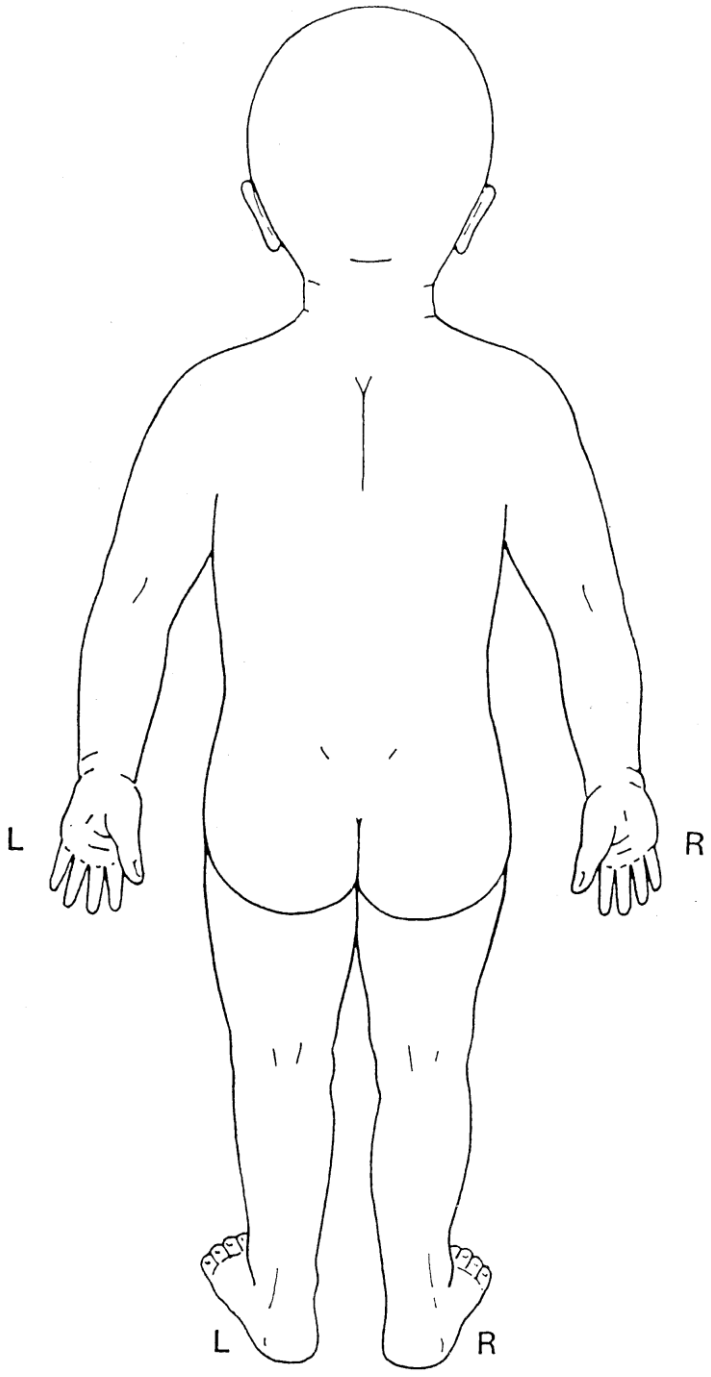

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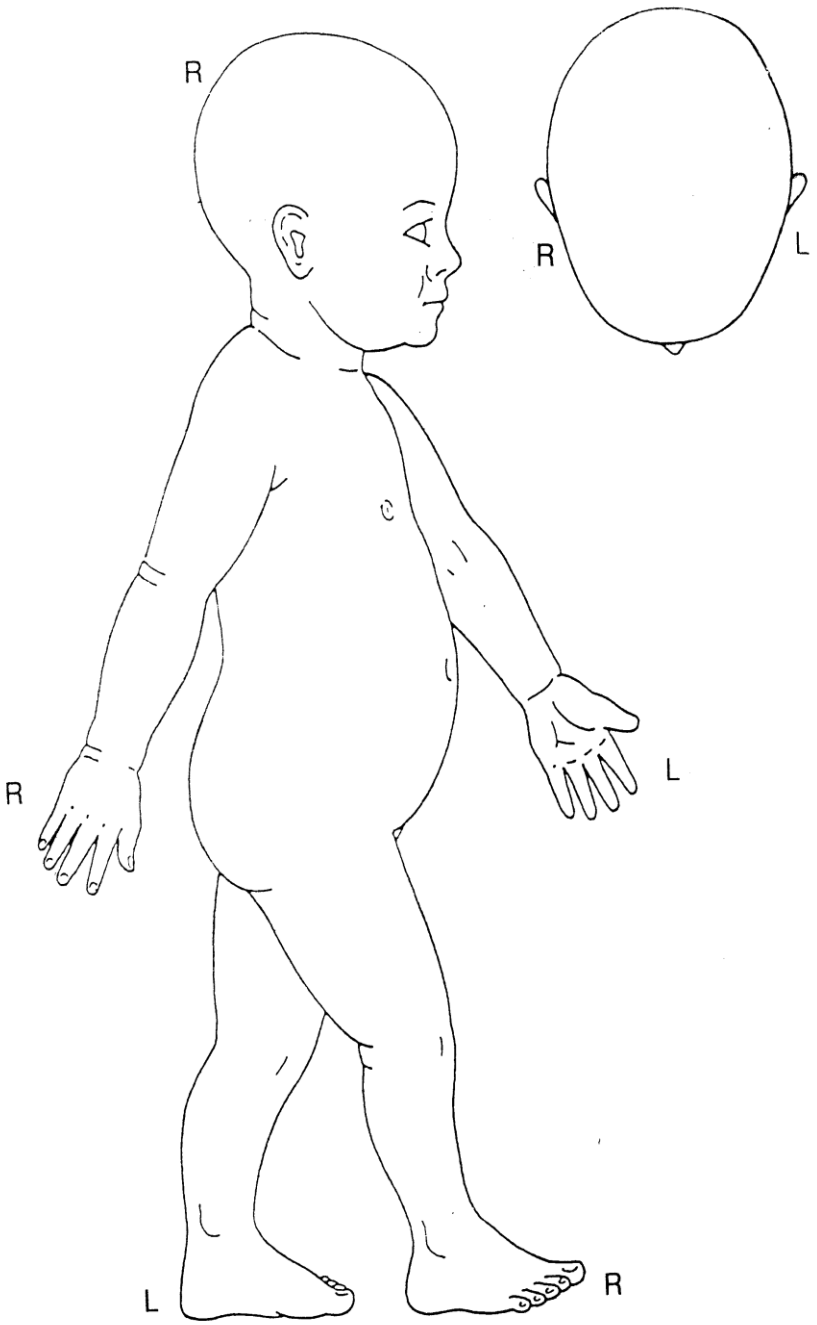

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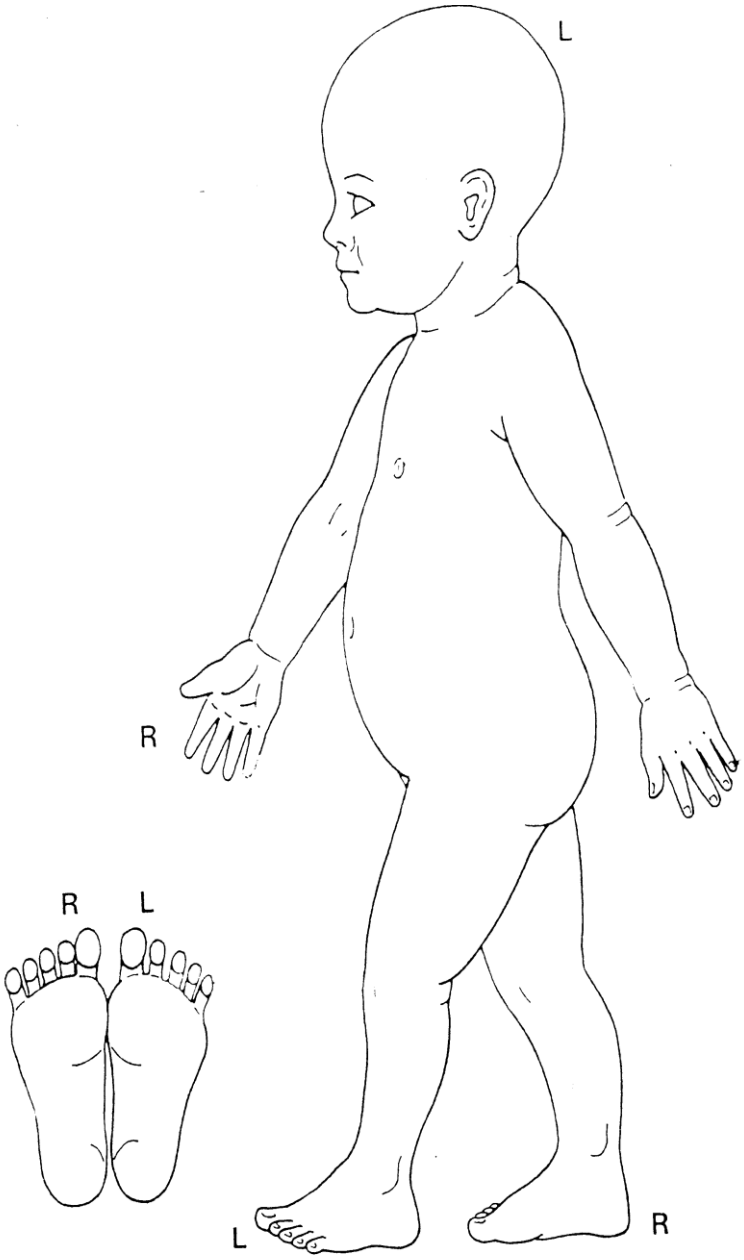

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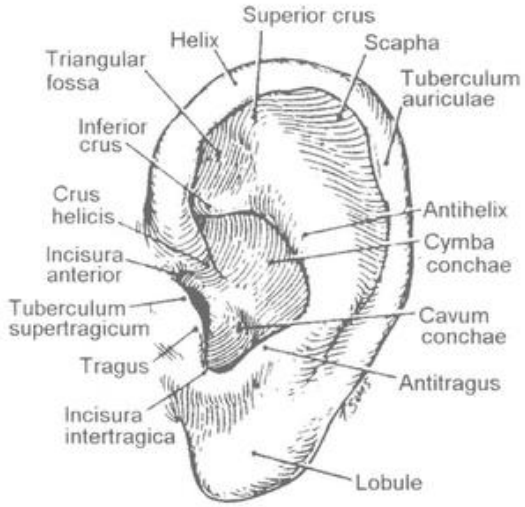

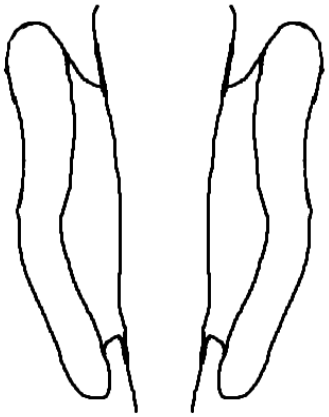

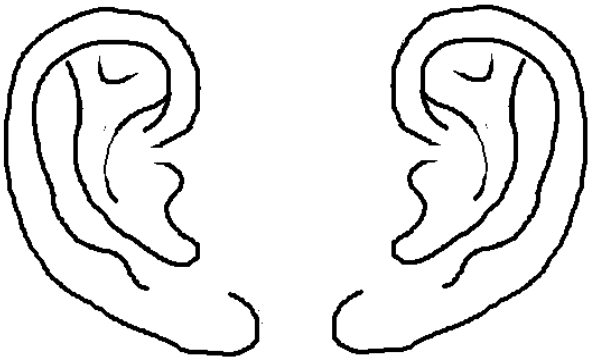

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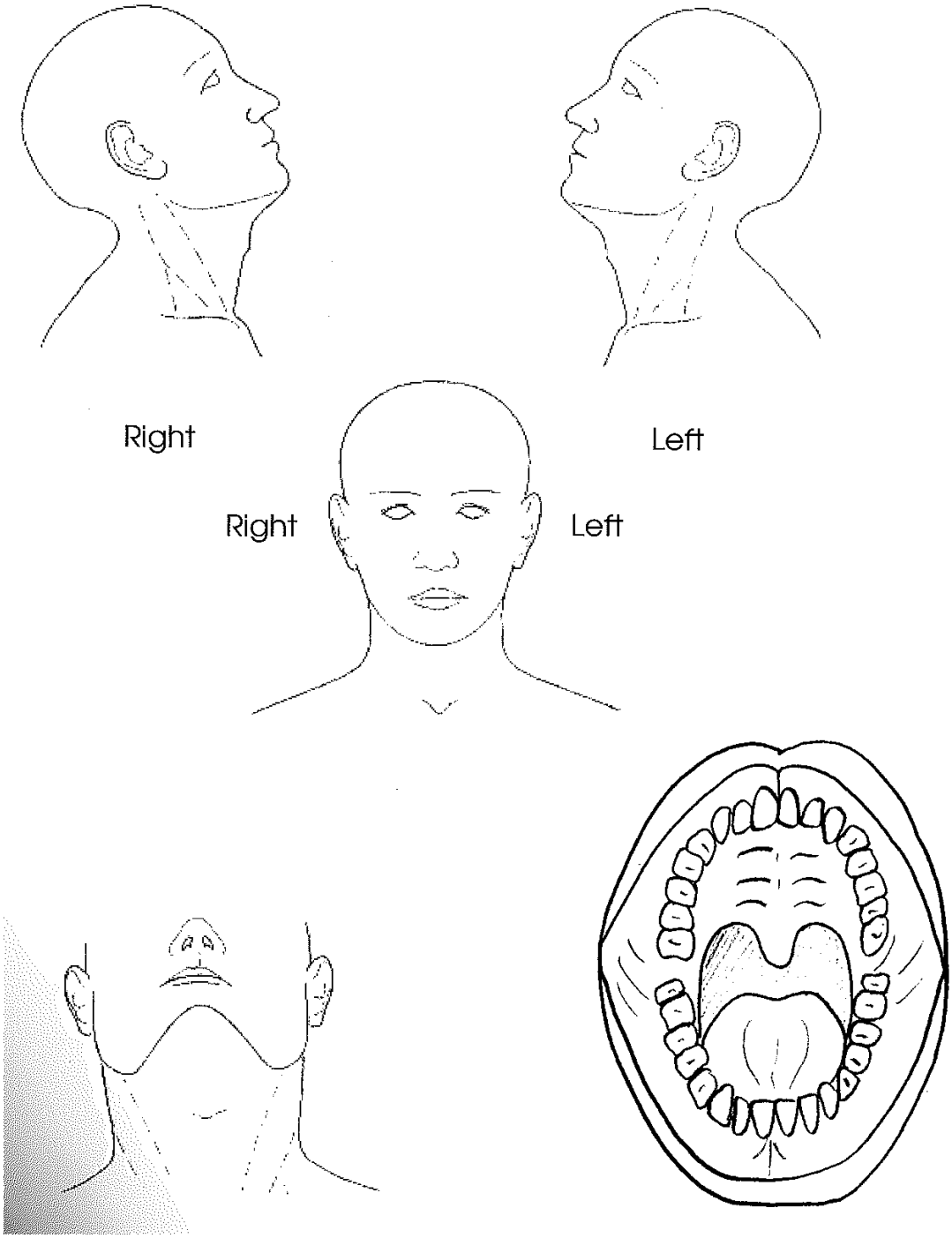
Other comments *(e.g date marks first noted, by whom)*



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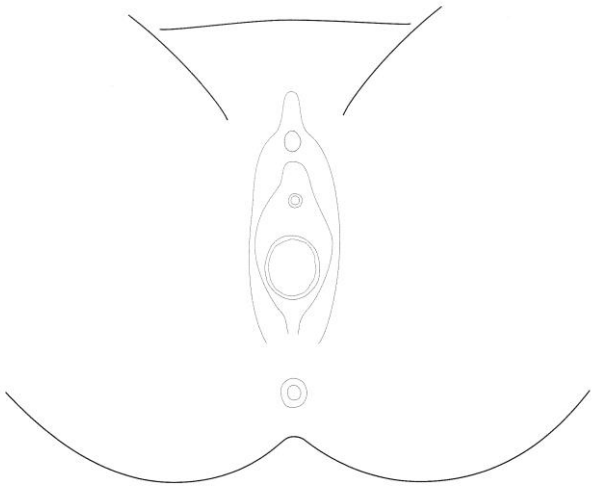

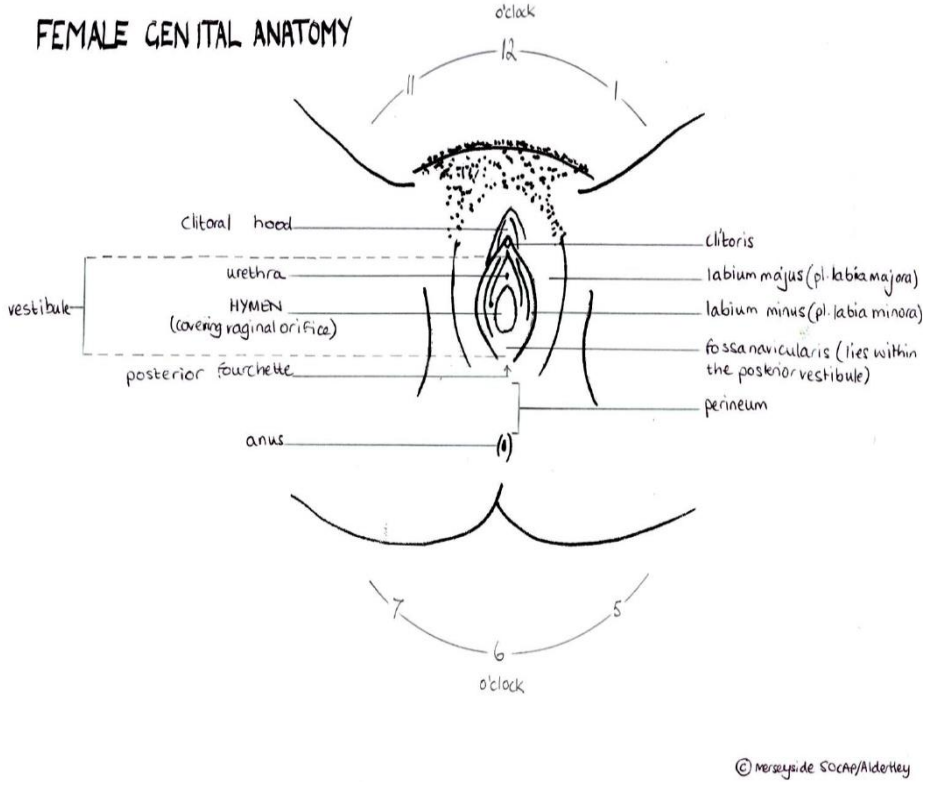

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