Bradford, Calderdale, Kirklees and Wakefield Safeguarding Children Partnerships

Assessment of non-mobile babies with injuries, including bruises, burns and scalds

1	Introduction – Guiding Principles
1.1	This protocol has been agreed by the **Bradford, Calderdale, Kirklees** and **Wakefield** Safeguarding Children Partnerships. It is relevant to any practitioner operating within the Bradford, Calderdale, Kirklees, and Wakefield Local Authority areas who may come into contact with babies who are not yet self-mobile, and who identifies that such a baby has received an actual or suspected bruise burn or scald defined in paragraph 2.2 below. Practitioners working in Leeds should refer to the following guidance: Multi-Agency Bruising Protocol in Non-independently Mobile Children Multi-Agency Protocol for the Assessment of Suspected Neglectful or Inflicted Burn or Scald Injury
1.2	Bruising is the most common accidental injury experienced by children, and research shows that the likelihood of a baby sustaining accidental bruising increases as they become more mobile. The evidence also suggests that it is rare for a non-mobile baby, i.e. one that is not yet crawling, to sustain accidental bruising. Therefore, all such bruising in non-mobile babies should be viewed by practitioners as an indicator of possible physical abuse and, as such, should be thoroughly investigated. It should also be borne in mind that other unusual marks on the skin or unusual sites of bleeding, for example bleeding from the mouth and nose in a baby, a boggy swelling on the scalp or subconjunctival haemorrhages (blood within the white of the eyes) without a clear explanation, may also be a sign of non-accidental injury and should also be referred according to this protocol if there is any uncertainty.
1.3	Published evidence suggests that children under the age of 1 year old, particularly those under 6 months are most at risk of suffering physical abuse, where injuries may represent ''sentinel injuries''. There is considerable evidence in safeguarding literature for the concept of **"sentinel injuries"** which are visible or detected minor injuries in a pre-mobile infant that are unexplained/poorly explained. They can be a precursor for escalating abuse and are usually clinically insignificant. They are however often recognised retrospectively. These may include, for example, bruising, bleeding from the nose, abrasions, petechiae (pinpoint bleeding in the skin), burns, oral injuries, and subconjunctival haemorrhages. However, practitioners are reminded that **all** children are vulnerable to harm and, as such, they should remain alert to signs of abuse, unexplained or unusual injuries; or injuries where the explanation provided is not consistent with the injury sustained.
1.4	Working Together to Safeguard Children (2023) clearly identifies that no single practitioner can have a full picture of a child's needs and circumstances. This protocol is underpinned by the principle that effective safeguarding systems are child centred and support clear local arrangements for collaboration between practitioners and agencies. **This protocol requires that all actual or suspected bruising, burns or scalds to babies who are not yet self-mobile should be subject to multi-agency enquiries in order to assess risk of harm. For this reason, any**

practitioner who identifies such an injury to a non-mobile baby is required to make a referral to Children's Social Care, regardless of the explanation offered by parents or carers, and regardless of the practitioner's own opinion about how the injury may have been caused.

At the point of referral, an interim safety plan will be agreed between the referrer and Children's Social Care until further multi-agency discussions have taken place.

A decision that the child has not suffered abuse must be a joint decision and must not be made by an individual or single agency.

2 Terminology

2.1 Definition of Self-Mobile

This phrase refers to babies, who are to some degree independently mobile e.g. crawling, bottom shuffling, pulling to stand, cruising or walking independently. Please note however that some babies can roll from a very early age and this does not constitute self-mobility.

2.2 Medical Definition of Bruising

Bruising is caused by leakage of blood into the surrounding soft tissues, producing a temporary discolouration of skin, however faint or small, with or without, other skin abrasions or marks. Colouring may vary from yellow through green to brown or purple. This includes petechiae, which is a type of speckled bruising consisting of small red or purple spots, less than two millimetres in diameter and often presenting in clusters.

A haematoma is a bruise within the soft tissues beneath the skin but may not be associated with overlying skin discolouration. It should still prompt referral to children social care in line with this protocol. They may imply an injury from a significant force and present as swelling beneath the skin e.g. a soft/boggy swelling over the scalp which is often associated with an underlying skull fracture.

Subconjunctival haemorrhages refer to bleeding within the whites of the eyes and should be considered as similar to bruising to the eye itself for the purposes of this protocol.

2.3 Other Conditions that Mimic or Present with Bruises

There are a number of conditions that can mimic or present with bruises:

- Birth marks, such as Congenital Dermal Melanocytosis (also known as Slate Grey Nevus) or Strawberry Marks/Haemangioma, can frequently look like bruises.

- If a trained health practitioner is confident that the mark is a **birth mark and not a bruise** this can be clearly documented in the records and a referral under this protocol is **not** necessary. Birth marks may not be apparent at the time of birth and may appear or become more obvious over the first few weeks or months of life. If the examining practitioner is not confident the mark is a birth mark it would be appropriate in these cases to request a review by the GP or a Paediatrician, preferably within 24 hours, to determine the nature of the mark before a referral to Children's Social Care is made.

- Trauma around the time of birth is also very common in newborn babies and it is not uncommon to have injuries e.g. related to a forceps delivery or bleeding within the whites of the eyes (Subconjunctival haemorrhages) related to being squeezed during the birthing process. As with birth marks, if a trained health practitioner notes such an injury and is confident that it is related to birth, with no other safeguarding concerns, a referral under this protocol is not necessary. All findings and decisions should be clearly documented within the records. N.B Subconjunctival haemorrhages related to birth will usually have resolved by 2-3 weeks of age.

There are also several medical conditions that may present with bruising; these include clotting disorders,

	leukaemia, or infections such as meningococcal septicaemia. It is part of the child protection medical assessment to consider these possible causes and investigate further if clinically indicated. If there is a high level of suspicion that the marks seen are most likely related to an underlying medical condition, then it may be appropriate to discuss the case with the on-call consultant Paediatrician prior to a referral to Children's Social Care.
3	**Referring the child to Children's Social Care**
3.1	This protocol requires any practitioner who identifies an actual or suspected bruise, burn or scald to make a referral to Children's Social Care. This is because there is a significant possibility that such injury in a non-mobile baby may have arisen as a result of abuse or neglect.
3.2	The referrer should treat Children's Social Care as the first point of contact. They have a 24/7 service that deals with all requests for a Children's Social Care service, including concerns related to child abuse and neglect. **Bradford Initial Contact Point** - 01274 4333999 or Out of Hours 01274 431010 **Calderdale Multi-agency Screening Team (MAST)** - 01422 393336 or Out of Hours 01422 288000 **Kirklees Children's Social Care**- 01484 414960 **Wakefield Integrated Front Door** - 0345 8 503 503
3.3	**Informing the Parents/Carers and Obtaining Consent** It would be expected that, in most cases, the practitioner **will inform parents and/or carers** of their intention to make a referral and obtain their consent to do so. However, in judging whether to inform the parent/carer that a referral is to be made, the practitioner who has identified the suspected injury must consider the possibility that to do so may increase the level of risk to the baby. If the practitioner concludes that informing the parent/carer may increase the level of risk to the baby, they should consult with Children's Social Care or the child's allocated Social Worker before speaking to the parent to obtain advice. **In all cases, Children's Social Care must be advised if the parents or carers are aware of the referral, and the reasons for them not being so, or not having given consent, clearly stated.** **A referral to Children's Social Care should still be made if parents refuse consent, in order to safeguard the child.** Where parents and carers have been advised of a referral, it is good practice for parents and carers to be provided an information leaflet explaining injuries in non-mobile babies, why a referral has been made and the expected process. This information should be available in multiple languages.
3.4	Prior to making a referral, a practitioner should ensure that they have sufficient information. This includes basic details such as name, date of birth, address etc. as well as details of parents/carers / siblings including contact telephone numbers and any other relevant background information that is known at the time. **Upon identifying a concern, there should be no delay in making a referral to Children's Social Care.**
4	**Action to be taken by Children's Social Care**
4.1	Referrals made to Children's Social Care under this protocol will always be deemed to be high priority due to the vulnerability of the child concerned.
4.2	Where a referral is made to Children's Social Care, they will first check existing records to ascertain if the family is currently in receipt of a service. If this is found to be the case, the information will be recorded in detail on the electronic system and passed **immediately** to the responsible Social Worker or Team Manager, unless the referral is made out of hours, in which case the out of hours duty Social Worker will make an

	immediate assessment of risk. In all cases, Children's Social Care must confirm that the information/referral has been received by either the allocated Social Worker or Team Manager. This will require **immediate communication to ensure that there is no delay in the information or referral being actioned**. If neither is able to confirm receipt of the referral, Children's Social Care should liaise with another Team Manager to ensure that the referral is received and responded to.
4.3	If the baby or family are **not** already in receipt of a service, Children's Social Care will follow safeguarding children's procedures and record the information as a **high priority** referral. All referrals will be screened, which will involve interrogation of records by the Integrated Front Door to inform multi-agency decision making (MASH / MAST / appropriate named equivalents), unless the referral is made out of hours, in which case the out of hours duty Social Worker will make an immediate assessment of risk.
4.4	Following a referral being made from a source external to the hospital, screening will be undertaken with health, police and Children's Social Care to decide whether a Strategy Discussion / Meeting needs to take place. Where there are significant concerns then the case will progress to a Children's Social Care Locality Team where a strategy meeting will take place. It may be that at strategy discussion takes place initiated by the Integrated Front Door (MASH / MAST / appropriate named equivalents) or Emergency Duty Team if deemed appropriate. **As a minimum** this strategy discussion / meeting should include appropriate health and police representatives, including a Paediatrician, and take place on the same day, as early as possible so there is time to carry out further assessment in normal working hours if necessary. A strategy discussion can take place following the referral or at any other time, including during the assessment process and when new information is received. Whilst it is hoped in these circumstances a medical assessment is a priority and available at this point, should there be a delay in the medical assessment the strategy discussion in turn should not be delayed. Following a referral being made from a hospital by a Paediatrician who has assessed the injury, a "professional discussion" should be held in which information is gathered and shared and a decision made about whether the case needs to progress to a formal strategy discussion.
4.5	West Yorkshire Consortium Safeguarding Children Procedures in relation to Strategy Meetings and Discussions can be found at: Strategy Discussions / Meetings
4.6	Strategy Meetings / Discussions should also involve any other agency that may hold information about the family, as far as is practicable given the time of the referral. Strategy Meetings / Discussion minutes should be sent to all attendees.
5	**Referrals Made Outside of Office Hours – the role of Children's Social Care**
5.1	In cases where information is received outside normal office hours, the Emergency Duty Team (EDT)/Out of Hours service in Children's Social Care will be required to begin the process of conducting a 'Professional Discussion' with Children's Social Care, the Police and Health services, including the on-call Paediatrician regardless of whether the child or family has an allocated social work already. **It is not acceptable to allow the matter to wait until normal office hours have resumed.**
5.2	In cases where EDT / Out of Hours Children's Social Care commences a Section 47 Enquiry, this will be transferred to the appropriate team who will undertake multi agency information gathering when normal office hours have resumed. The transfer will involve direct communication between EDT / Out of Hours Children's Social Care and the Social Worker or Team Manager and will require full records to be entered onto the electronic system by Children's Social Care without delay by the allocated Social Worker.

6	**West Yorkshire Police**
6.1	Where information relating to a suspected or actual bruise, burn or scald to a non-mobile baby is received by West Yorkshire Police from another source, Police Child Safeguarding officers will refer the matter to the Children's Social Care and participate in a Professional Discussion / Strategy Meetings if one takes place.
6.2	On the basis of this Strategy Meeting / Discussion, a plan for the investigation and assessment of the suspected injury will be developed jointly, in line with the West Yorkshire Consortium Inter Agency Procedures
7	**The Paediatric Assessment**
7.1	The Paediatrician on call for safeguarding will participate in all Professional Discussions, Strategy Meetings/Discussions that are initiated in line with this Protocol.
7.2	Where information relating to an actual or suspected bruise, burn or scald is received by a member of the Paediatric team (for example a baby attending the Emergency Department with an injury) they will themselves refer the matter to Children's Social Care and participate in a Professional Discussion which may or may not advance to a formal Strategy Meeting.
7.3	All babies referred to Children's Social Care under this protocol **must have a medical assessment.** The medical assessment should be carried out by a Paediatrician with the appropriate training, competencies, and supervision as per *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (RCPCH 2019).* A Paediatrician should assess the injury to inform the Professional discussions, Strategy Meeting/ Discussion.
7.4	Where Children's Social Care receives a referral for a non-mobile baby with an injury from outside a hospital, once a Strategy Meeting / Discussion has confirmed that a Section 47 Enquiry is required under the terms set out in this protocol, an assessment by a Hospital Paediatrician must take place, and parents/carers **must not** be asked to take the baby to the hospital Emergency Department or to their GP as an alternative. Wherever possible, a member of Children's Social Care staff should attend the examination. If the family is already known to social care, then a Social Worker who is familiar with the family should ideally attend. However, in cases where this is not possible (e.g. with a family who are not previously known to Children's Social Care), the worker(s) attending with the family should be familiar with the referral that has been made and the nature of the suspected injury etc.
7.5	The Paediatrician should arrange for additional medical investigations if the circumstances warrant this. The Paediatrician will provide a verbal opinion at the time of the medical assessment, which will be followed up in writing within 72 hours, unless it has agreed that it will be sooner. The Royal College of Paediatrics and Child Health standards for Child Medicals provides guidance that Paediatricians should provide a provisional short written report after a medical assessment to enable decision making. If the allocated social worker / Children's Social Care, upon receipt of the report, are unclear about the medical opinion, they must contact the Paediatrician to seek clarification.
8	**Decision Making**
8.1	The key principle of this protocol is that when a non-mobile baby has sustained injuries as outlined in this document, decisions should **not** be made by a single agency. As a minimum, decisions should be made by a group consisting of a **Social Worker, Police Officer and Paediatrician.** This protocol does not seek to remove or undermine professional judgement, but rather to support it (and encourage professional challenge where appropriate) in a multi-agency environment to ensure the best outcomes for children and families.

8.2	If the case progresses to a section 47 enquiry, then at the close of the Section 47 Enquiry, Children's Social Care should have made an assessment in relation to whether the baby has suffered, or is likely to suffer, significant harm. This assessment should have been developed in full consultation with all relevant partner agencies.
8.3	In some cases, the outcomes of the Section 47 Enquiry may not be clear, for example, the findings of the Paediatric assessment may be inconclusive or agencies may hold differing views about the level of risk. In such cases another Strategy Meeting / Discussion should be convened and chaired by a Team Manager or Advanced Practitioner from Children's Social Care in line with West Yorkshire Consortium Safeguarding Procedures. The process of bringing the relevant practitioners together to discuss the case may contribute to better assessment and outcomes.
8.4	This assessment will inform the action to be taken by Children's Social Care and/or West Yorkshire Police. Where applicable the measures put in place by Children's Social Care and West Yorkshire Police in respect of the agreed plan relating to parental or carer contact with a baby, from the point of referral until the concern has been explored, must be adhered to. Hospitals are not deemed to be a place of safety nor is it appropriate for health staff to supervise parents and carers that may be present with a baby.
8.5	Where there is professional disagreement the case should be referred to relevant managers or equivalent for resolution in line with Resolving Multi Agency Professional Disagreements and Escalation
8.6	Children's Social Care should also ensure that the outcomes of the Section 47 Enquiry are shared with the family (unless to do so would place the baby at increased risk) and all relevant partners, this includes the referrer and Paediatrician, GP and 0-19 Services (such as health visitors and school nurses).
8.7	In all agencies, the outcomes of the Section 47 Enquiry should be recorded in detail. This is particularly important where a decision is taken that no further action is required to protect the baby.
9	**Timescales**
9.1	It is expected that all referrals under this protocol will be responded to, and assessment commenced on the same day that the referral is received. If this is not possible, then arrangements should be made for assessment to commence at the start of the following day at the latest (apart from weekends and bank holidays). **In all cases, a Strategy Meeting / Discussion and Paediatric Assessment should have been undertaken within 24 hours of receipt of the referral.**