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Policy on Management of Bruising and Injuries in Non-Mobile Infants and Children

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| **Distribution:**   * GPs & GP sub group * All Paediatric and Community Paediatric Staff * Child Protection Advisors (Health) * Integrated Family Teams, Highland Council * Associate Lead Nurse (Health) for Child Protection & CEC&YP * Emergency Department Staff * Dental Staff * CAMHS * Dept of Radiology * Dept of Dermatology * Minor injury units staff | * Child Protection Committee Chair * Health Visitors * School Nurses * Lead Nurse Highland Council * Associate lead nurses (THC) * FNP supervisor & FN’s * Principal Social work Officer, Highland Council * Principal Officer for Allied Health Professionals * Audiology/ENT * Dept of Surgery * Dept of Anaesthesia * Dept of Ophthalmology * Police Public Protection Unit, North Division |

1. **Introduction and aim of this guidance**

This is designed to support all frontline staff in both community and hospital settings to assess, describe and plan the management of a child who presents with bruising or other injuries and who is not yet independently mobile.

It aims to ensure that professionals in all agencies:

* are aware that even minor injuries could be a pointer to serious abuse in pre-mobile babies
* know that such injuries, however plausible, must routinely lead to multi-agency information sharing
* know how to refer such a baby for a medical opinion
* know whom to contact for safeguarding purposes.

1. **Definitions**

Non-mobile: Includes all children aged under 6 months. Includes older children who are not yet crawling, bottom shuffling or pulling to stand, cruising around furniture or walking. Some children may roll at a young age but this policies applies to all those under 6 months, even if they are rolling.

Trauma and Injuries: Includes burns, bruises, scalds, lacerations, incisions and fractured bones. Scratches may be self-inflicted.

Blunt trauma is physical trauma to a body part, either by impact, injury or physical attack. Non-penetrating blunt force trauma can cause bruising or fractures. Penetrating trauma is an injury that occurs when an object pierces the skin and enters a tissue of the body, creating an open wound.

1. **Importance of bruising: research findings**

Research on bruising in children shows that it is the commonest presentation of child physical abuse (1), but it can also be a sign of medical illness. In very young non-mobile children bruising is highly predictive of physical abuse (2). Staff working with children should have the knowledge and skills to be aware of when bruising is likely to be normal, when it is of concern and when it requires further investigation and referral to specialist services.

Systematic reviews of evidence show the following:

Features of concerning bruising include:

* Bruises in clusters.
* Bruises with petechiae.
* Bruises away from bony prominences i.e. on soft tissue areas such as cheek, buttocks, trunk etc.
* Bruises that carry the shape of a hand, ligature or implement.

Bruising in non-mobile children is very unusual.

Only 1 in 5 infants who are starting to walk by holding onto furniture (cruising) has bruises.

Most children who can walk independently have bruises.

Non-accidental head injury or fractures can happen without bruises.

1. **Sources of further information**

The following websites are useful sources of current research and up to date information on this topic:

RCPCH Child protection Evidence – Bruising

<https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising>

NICE guideline ‘Child abuse and neglect’ and ‘Child maltreatment: when to suspect maltreatment in under 18s’

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

<https://www.nice.org.uk/guidance/cg89/chapter/1-Guidance>

NSPCC: <https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/physical-abuse/signs-symptoms-effects/>

1. **Health staff: Assessment of a non-mobile child with bruising**

**APPROXIMATE DEVELOPMENTAL MILESTONES IN FIRST YEAR OF LIFE**

1-4 weeks: Loves looking at faces, can fix and follow.

6 weeks: develops a social smile.

4-12 weeks: lifts head while lying prone, starts to roll.

3-5 months: reaches out for objects.

5 months: mouths all objects.

6 months: passes objects from one hand to another.

6-8 months: starts to sit without support.

6-9 months: starts trying to crawl.

9-11 months: learns to drop items.

10-18 months: learns to walk, very unsteady at first.

* Take a history for the bruise or injury. Document the explanation using the parent’s own words.
* Ask about:
  + Other illness/concerns
  + Family history of bleeding/bruising
  + Child on the child protection register or is ‘looked after’ or has a social worker.
* Ask yourself:
  + Is there a delay in presentation?
  + Does the bruise or injury fit with the explanation given?
  + Does the bruise or injury fit with the child’s stage of development?
* Look for any other injury by carrying out a top to toe examination.
* Document your findings on a body map with measurements.
* Keep parents updated.

**If you see a bruise in a non-mobile baby, there should be a Child Protection discussion and medical review on the same day unless it is agreed with social care (care and protection) that the medical can wait until the next day.**

PROTOCOL FOR INJURIES IN IMMOBILE CHILDREN

Professional observes an injury, bruise or suspicious mark

SUSPECT CHILD MALTREATMENT

Is the child seriously ill or needs emergency treatment?

Signs of head trauma include: abnormal drowsiness; unusual eye movements; vomiting or poor feeding; fits; apnoea (pauses in breathing)

NO

Seek an explanation, examine and record accurately – include details of social history and other children and carers

YES

**A SICK CHILD SHOULD BE REFERRED IMMEDIATELY TO HOSPITAL**

Explain to carers the reason for immediate referral to Paediatrics and Children’s Social Care (Care & Protection)

Referral to social work (care and protection) triggers Interagency Referral Discussion (IRD) between health, police and social work.

Child is seen and any immediate health needs met (in emergency dept if needed). Child is assessed by paediatrician. Initial conclusions are made, further investigations may be awaited. Carers are updated.

Paediatrician to share initial results of assessment and any concerns through IRD process with social work/ police/ child protection advisor as is practical.

Social work contact details for each area of Highland are available from:

<https://www.highland.gov.uk/info/1347/social_care_and_health/456/social_care_contacts>

For out of hours concerns, contact the duty social worker on:

Tel 08475 697284

Child protection nurse advisor contacts are available on NHS Highland intranet child protection page and from: http://hcpc.scot/professionals/

Appendix 1. ASSESSMENT & INVESTIGATION OF INJURIES IN NON-MOBILE CHILDREN (RAIGMORE HOSPITAL)

All sick and unwell children should have their immediate healthcare needs met as a priority.

The lack of a satisfactory, or consistent, explanation or an explanation incompatible with the appearance or circumstances of the injury, or with the child’s age, or stage of development, should raise suspicions of abuse.

A full physical examination of the completely undressed child should be undertaken. This should include weighing, observation of general demeanour, cleanliness, infestations, nourishment and body proportion, as well as looking for other bruising or evidence of injury. If available, the child’s growth chart should be examined.

A review of the child's medical history, including any previous occurrence of bruising or injury, should be undertaken and information sought from general practice and the health visitor. Consideration should be given to identified vulnerabilities within the family such as domestic abuse, substance misuse, mental health issues and deliberate self-harm.

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

In all cases careful mapping, description and recording of the size, colour characteristics, site, pattern and number of the bruises should be made and a careful record of the carers/parents description of events and explanation for the bruising made in the clinical notes.

PLEASE USE THE NATIONAL CHILD PROTECTION PROFORMA - COPIES ARE ON THE WARD & AVAILABLE TO DOWNLOAD FROM THE INTRANET.

If a congenital condition, dermal melanocytosis, haemangioma etc. or sucking bruise (where the child has been observed by a professional sucking that area) is seen then complete checks and reassure carer. Communicate findings to GP/ social work/ police/ HV. Be aware that physical abuse and congenital marks can co-exist.

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| Note keeping | * Body maps are very useful and included with the proforma * Obtain medical photographs from medical illustration (or via police if necessary) |
| Investigations for infants or children under 2 years | Consider the following as first line for bruising in a pre-mobile infant and check the child protection companion for additional tests:   * Coag screen (PT, aPTT, thrombin time, Fibrinogen) * FBC * Assays of factor VIIIc, VWF antigen & VWF activity   **If a skeletal survey is being carried** out then bone investigations should be done at the same time as blood is taken for bruising concerns – these investigations include: calcium, phosphate, alkaline phosphatase, vitamin D and parathyroid hormone. |
| Investigations for older children | The extent of blood investigations will depend on the injuries seen. A FBC and basic clotting screen is recommended to show an injured child has no underlying propensity to bruise easily, in the context of a child protection investigation. |
| Imaging | It is recommended that a CT head scan is included in the investigation of any infant under one year of age where there is evidence (signs or suspicion) of physical abuse, and should be considered in children up to the age of two years. Consider if skeletal survey needed. |

ABUSIVE HEAD TRAUMA (AHT)

*Child protection companion (2013)*: AHT is the commonest cause of death in physical child abuse. It is predominantly seen in children under the age of two; most commonly in those under six months of age. The mortality from AHT is up to 30%. Half of the survivors have residual disability of variable severity.

It is widely accepted that AHT arises from severe repetitive rotational, acceleration-deceleration injury (from shaking) with or without additional impact, or impact alone.

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| Brain imaging | Neuroimaging is the definitive diagnostic investigation and should be performed where AHT is suspected i.e. urgent head CT  Indications for neuroimaging include:   * Unexplained sudden collapse * Neurological signs or symptoms * Enlarging head circumference * Persistent uniform CSF bloodstaining * Haemorrhagic retinopathy |
| Eyes | Arrange for an examination by an experienced ophthalmologist as soon as possible in order to exclude eye injury, including retinal haemorrhage  If there are positive signs, follow up with MRI. In some circumstances MRI is suitable first line if agreed with radiology. |
| Bones | Skeletal survey including skull films if the child is well enough. If the child is too unwell then the survey should be done as soon as is possible without compromising the clinical condition of the child. |
| Bloods | FBC, coag. Consider septic screen. Extended coagulation screen. |
| Fluids | Urine for toxicology screen or if concerned re: glutaric aciduria (discuss with metabolic team) |
| Other imaging or investigations | Consider other imaging (visceral etc) depending on clinical history, signs and symptoms. Have a low threshold if child has multiple soft tissue injuries, abdominal bruising or suspected inflicted head trauma. |

For more information on retinal haemorrhage, see RCPCH child protection evidence series (RCPCH 2020) https://childprotection.rcpch.ac.uk/child-protection-evidence/retinal-findings-systematic-review/

**SOUL & CONSCIENCE REPORTS** ARE ONLY REQUIRED IF THERE HAS BEEN A CHILD PROTECTION (CP) INVESTIGATION WHICH INVOLVES POLICE & SOCIAL CARE. IF THE CAUSE OF THE MARK IS CONGENITAL/ BENIGN AND THERE IS A CP INVESTIGATION, A SOUL & CONSCIENCE REPORT IS STILL NEEDED.

GP LETTER FROM THE CONSULTANT PAEDIATRICIAN IS OTHERWISE SUITABLE COMMUNICATION.