



# **Bruising in Children who are Not Independently Mobile**

## **A Protocol for Assessment, Management and Referral by Practitioners**

### **Aim of Protocol**

The aim of this protocol is to provide frontline 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 suspicious marks.

It does not reiterate the process to be followed once a referral to Social Care has been made. For this, practitioners must consult the Warrington Safeguarding Children Board Child Protection Procedures at [www.warringtonlscb.org](http://www.warringtonlscb.org)

**Target Audience:** All frontline staff working directly with children including general practitioners including sessional doctors, locums and 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; all community and hospital paediatric clinical staff.

**Date for Review:** January 2014 – completed

## 1. Introduction

- 1.1 Bruising is the commonest presenting feature of physical abuse in children. Learning from child protection cases indicates that the highly predictive value for child abuse, of the presence of bruising in children who are not independently mobile can be underestimated or ignored (those not yet crawling, cruising or walking independently).  
As a result there have been a number of cases where bruised children have suffered significant abuse that might have been prevented if action had been taken at an earlier stage.
- 1.2 The NICE guideline "When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009)" states that bruising in any child not independently mobile should prompt suspicion of maltreatment. See: <http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English>
- 1.3 In the light of these findings this joint protocol 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 Targeted Services Social Work Service. The protocol has been approved by the Warrington Safeguarding Children Board.
- 1.4 In the light of the NICE guideline and the research base outlined in section 3 this protocol is necessarily directive. While it recognises that professional judgement and responsibility have to be exercised at all times, it errs on the side of safety by requiring that **the majority of children with bruising who are not independently mobile be referred to Targeted Services Social Work Service and for a consultant paediatric opinion to be sought.** Professionals should always have a higher rate of suspicion when a child is not independently mobile and there is no explanation for the injury, or the explanation is inconsistent or the practitioner is of the view the explanation appears unlikely.

## 2. Definitions

- 2.1 **Not Independently Mobile:** a child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently.
- 2.2 **Bruising:** extravasation of blood in the soft tissues, producing a temporary, non-blanching 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 are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

## 3. Research base

- 3.1 There is a substantial and well-founded research base on the significance of bruising in children. (See Appendix I [www.nspcc.org.uk/core-info](http://www.nspcc.org.uk/core-info))
- 3.2 Although bruising is not uncommon in older, mobile children, it is rare in infants that are immobile, particularly those under the age of six months. While up to 60% of older children who are walking have bruising, it is found in less than 1% of not independently mobile infants. Moreover, the pattern, number and distribution of innocent bruising in non-abused children is different to that in those who have been abused. Innocent bruises are more commonly found over bony prominences and on the front of the body but rarely on the back, buttocks, abdomen, upper limbs or soft-tissue areas such as cheeks, around the eyes, ears, palms or soles,

### 3.3 Signs of Bruising

3.3.1 Bruising is the commonest presenting feature of physical abuse in children.

The following features indicate an increased risk that bruising is due to abuse rather than to accidental or medical reasons. Consideration should be given to the degree, if any, to which these features are present taking into account the age and ability of the child:

- Bruising on the head especially the face, ears and neck
- Multiple bruising especially of uniform shape or symmetrical positions
- Bruises in clusters
- Large bruises
- Bruising on soft tissues (away from bony prominences) especially cheeks and around eyes
- Bruising on the abdomen, upper limbs (especially arms and hands), buttocks and back
- Bruising around the anus or genitals
- Imprints and patterns including 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.
- Petechiae
- A boggy forehead swelling with peri-orbital oedema (caused by violent pulling of the child's hair)
- Accompanying injuries such as scars, scratches, abrasions, burns or scalds
- Bruising in disabled children

3.3.2 Features of innocent bruising:

- In mobile children, the commonest sites of bruising are the shins and the knees
- bruising as a result of trips and falls is commonest on the back of the head, the front of the face, including the forehead, the nose, upper lip and chin
- Children who are pulling to stand may bump their head sustaining bruising to the forehead
- However, these features may also occur in abused children and it is important to re-emphasise that any bruising in a not independently mobile child is unusual

- 3.4 **A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. A full clinical examination and relevant investigations must be undertaken.**
- 3.5 **The younger the child the greater the risk that bruising is non-accidental and the greater potential risk to the child.**
- 3.6 **Children with disabilities and in particular disabilities which restrict their mobility and who rely on their carers to meet their personal care needs are also highly vulnerable. Any bruising of a non - accidental nature in such children also indicates a greater potential risk.**

#### **4. Scope of Protocol**

- 4.1 In the case of newborn infants where bruising may be the result of birth trauma or instrumental delivery, professionals should remain alert to the possibility of physical abuse even in a hospital setting. In this situation clinicians should take into account the birth history, the degree and continuity of professional supervision and the timing and characteristics of the bruising before coming to any conclusion. It is particularly important that accurate details of any such 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 should refer immediately to the duty consultant (or associate specialist) paediatrician.**
- 4.2 Any bruising, or what is believed to be bruising in a child of any age that is observed by, or brought to the attention of a health professional should be taken as a matter for inquiry and concern.
- 4.3 It is not always easy to identify with certainty a skin mark as a bruise. Practitioners should take action in line with this protocol if they believe that there is a possibility that the observed skin mark could be a bruise or could be the result of injury or trauma.
- 4.4 While accidental and innocent bruising is significantly more common in older mobile children, professionals are reminded that mobile children who are abused may also present with bruising (Baby Peter 2008). They should seek a satisfactory explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history, to ensure that it is consistent with an innocent explanation.
- 4.5 Immobility, for example due to disability, in older children should particularly be taken into account as a risk factor. Disabled children have a higher incidence of abuse whether mobile or not.
- 4.6 The largest and most recent study is that carried out by Patricia Sullivan and John Knutson (Sullivan and Knutson, 2000) who analysed computer records on over 40,000 children in an American city. They found that disabled children were 3.4 times more likely to be abused or neglected than nondisabled children. Research in the United Kingdom in relation to abuse and the safeguarding of disabled children has been extremely limited.
- 4.7 One UK-wide survey (Cooke, 200) found that, although 51 per cent of local authorities said they recorded whether an abused child was disabled, only 14 per cent could actually give a figure. This confirmed earlier research, which found that, even when local authorities did include a record of disability in their child protection procedures, a lack of a common

definition and inconsistent recording meant the information was not available (Morris, 1998b).

This same research was able to gather information from one local authority area about the numbers of disabled children on the Child Protection Register. This established that, although disabled children made up only 2 per cent of the local child population they accounted for 10 per cent of the children on the Child Protection Register. Looked at another way, 9.5 per 1,000 disabled boys were on the Child Protection Register compared to 2.2 of non-disabled boys while the equivalent figures for girls were 15 and 2.3 (Morris, 1999).

## **5. Emergency Admission to Hospital**

- 5.1 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.
- 5.2 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**
- 5.3 It should be noted that children may be abused (including sustaining fractures, serious head injuries and intra-abdominal injuries) with no evidence of bruising or external injury.

## **6. Referral to Children's Social Care**

- 6.1 **Where a decision to refer is made, it is the responsibility of the first professional to learn of or observe the bruising to make the referral in line with Pan Cheshire LSCB Safeguarding Procedures <http://www.online-procedures.co.uk/pancheshire/>**
- 6.2 If a referral is not made, the reason must be documented in detail with the names of the professionals taking this decision.
- 6.3 Referral should, in the first instance, be made by phone:

**During office hours** (9.00am – 5.00pm, Mon – Thurs, 9.00 am – 5.00pm Fridays)

**Warrington: 01925 443400**

**At all other times** (including weekends and over Bank Holidays)

**Cheshire West and Chester Emergency Duty Team: 01244 977277**

- 6.4 All telephone referrals must be followed up within 48 hours with a written referral, using the appropriate Multi-Agency Referral Form and must be fully documented in the patient records.
- 6.5 The referrer should record the joint action plan agreed with Children's Targeted Services Social Work Service including any health follow-up.

## 7. Involving Parents or Carers

- 7.1 As far as possible, parents or carers should be included in the decision-making process unless to do so would jeopardise information gathering or pose a further risk to the child.
- 7.2 In particular professionals should explain at an early stage why, in cases of bruising in not independently mobile children, additional concern, questioning and examination are required. The decision to refer to a paediatrician and to Children's Social Care, should be explained clearly.
- 7.3 If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children's Targeted Services Social Work Service. The child should be kept under supervision until steps can be taken to secure his or her safety.

## 8. Innocent Bruising

- 8.1 It is recognised that a small percentage of bruising in not independently mobile children will have an innocent explanation (including medical causes). Nevertheless because of the difficulty in excluding non-accidental injury, practitioners should seek advice from Children's Targeted Services Social Work Service in all cases.
- 8.2 It is the responsibility of Children's Targeted Services Social Work Service in conjunction with the local acute or community 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.
- 8.3 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.**

## 9. Sharing Information and Consulting Colleagues.

- 9.1 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.
- 9.2 Whenever possible, the child's parent or carer should 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 (*Information Sharing: Guidance for Practitioners and Managers HM Government 2008*). "The 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 2010*)

## 10. History Taking and Examination by Health Care Professionals

- 10.1 A cogent and credible explanation for the bruising should 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.

- 10.2 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.
- 10.3 If possible history should be sought from more than one carer separately or more than once from the same carer. It should be recorded clearly who gave the history and who was present. Inconsistencies or variations between carers or between interviews should raise suspicions of abuse.
- 10.4 A full physical examination of the 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.

- 11.5 A review of the child's medical history, including any previous occurrence of bruising or injury, should be undertaken and, in general practice, the health visiting records examined. Consideration should be given to identify vulnerabilities within the family such as domestic abuse, substance misuse, mental health issues and deliberate self - harm. All information should be included in the referral to Children's Social Care and the paediatrician.
- 11.6 Where a history of previous child protection concerns is given by Children's Social Care this information must be recorded in the health record.
- 11.7 In all cases careful mapping, description and recording of the size, colour characteristics, site, pattern and number of the bruises should be made preferably on a body diagram (Appendix), and a careful record of the carers/parents description of events and explanation for the bruising made in the clinical notes. GP records should be flagged as "at risk".

**11.8 The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be overemphasised. 12 . Other Sources of Guidance and Information**

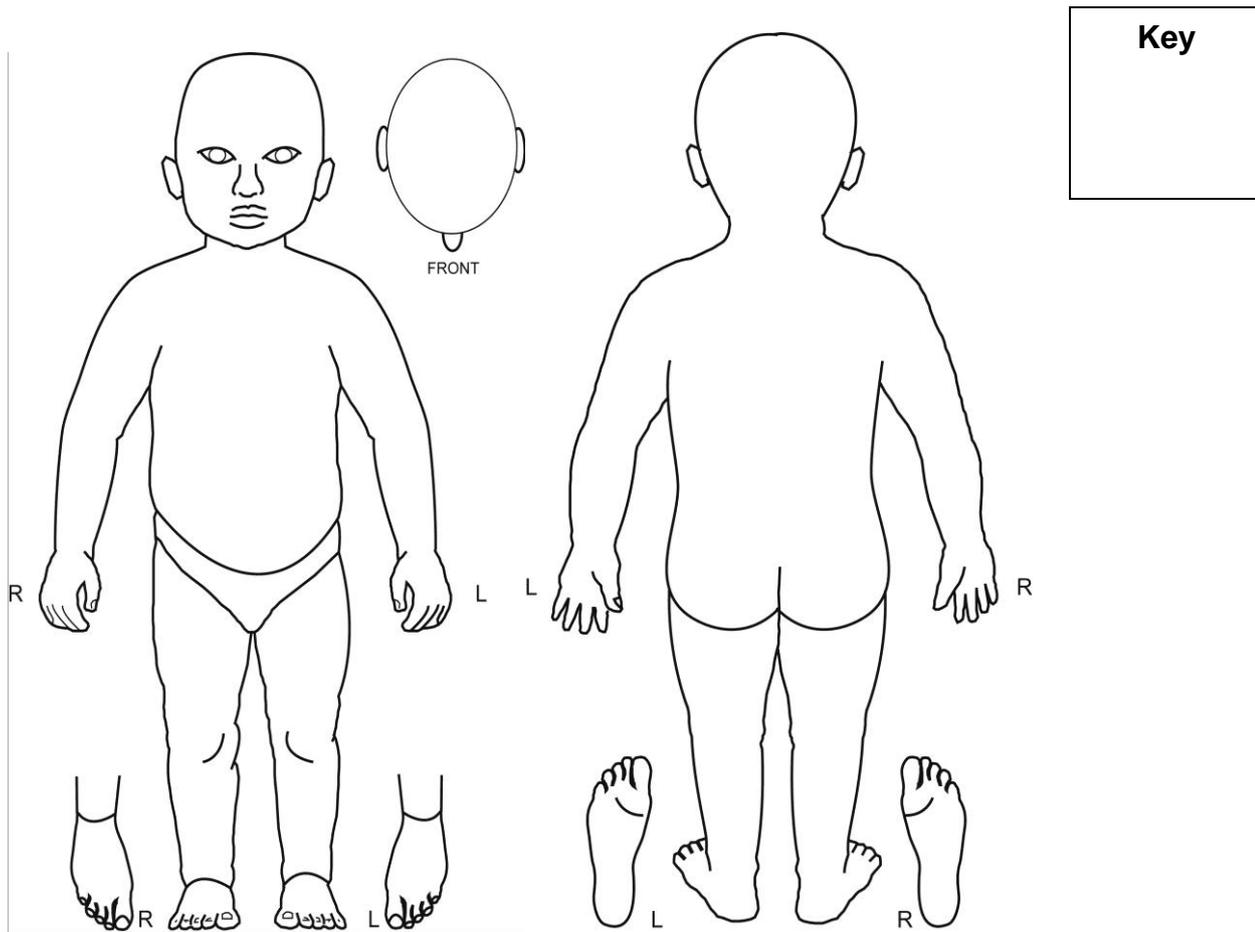
Working Together to Safeguard Children, HM Government, 2010  
<http://www.workingtogetheronline.co.uk/resources.html>

What to Do If You Are Worried a Child Is Being Abused, HM Government, 2006  
<http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182/>

Child Protection Companion, Royal College of Paediatrics & Child Health, April 2006  
[http://www.rcpch.ac.uk/doc.aspx?id\\_Resource=1521](http://www.rcpch.ac.uk/doc.aspx?id_Resource=1521)

When to Suspect Child Maltreatment (NICE Clinical Guideline 89, July 2009)  
<http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English> .

# Appendix Skin Map



**Child's name:**

**Date of birth:**

**Date/time of skin markings/injuries observed:**

**Who injuries observed by:**

**Information recorded:**

**Date:**

**Time:**

**Name:**

**Signature:**