Bruising in Children

A Protocol for Assessment, Management and Referral by those working with children in Bath and North East Somerset

<table>
<thead>
<tr>
<th>Date approved by LSCB</th>
<th>Dec 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Fiona Finlay and Jill Chart</td>
</tr>
<tr>
<td>Date for review</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>Detail of review amendments</td>
<td>Revised Phone no. for Child Health Dept</td>
</tr>
</tbody>
</table>

We acknowledge the use, within this protocol, of substantial sections from the protocol published by Hampshire, Southampton, Portsmouth and IOW Local Safeguarding Children Board.
Aim of protocol

The aim of this protocol is to provide the children’s workforce in Bath and North East Somerset (BANES) and their managers with a knowledge base and action strategy for the assessment, management and referral of children who present with bruising and are Not Independently Mobile.

It does not reiterate the process to be followed once a referral to Children’s Social Care has been made. For this process staff must consult the South West Child Protection Procedures at www.SWCPP.org.uk

Target Audience: All front line staff and their managers who may have contact with children.

Date for Review: September 2016

1. Introduction

1.1 The safety of children and their protection is everybody’s business, especially members of the children’s workforce. Bruising is the commonest presenting feature of physical abuse in children. Recent national serious case reviews and local individual child protection cases across Bath and North East Somerset have indicated that staff have sometimes underestimated the significance of the presence of bruising in children who are not independently mobile (those not yet crawling, cruising or walking independently).

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

1.3 This protocol has been developed for frontline workers and managers, for the 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 for further assessment and investigation of potential child abuse.

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 all children with bruising who are not independently mobile be referred to Children’s Social Care who will then hold a strategy discussion with a consultant paediatrician.

2. Definitions

2.1 Not Independently Mobile: a child who is not crawling, bottom shuffling, pulling to stand, cruising or walking independently; includes all children under the age of six months and any children with a disability who are not able to walk independently.
2.2 **Bruising**: blood coming out of the blood vessels into 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 tiny red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

3. **Research base**


3.2 Although bruising is common in older, mobile children, it is rare in infants that are not mobile, particularly those under the age of six months. Kemp found that only 2.2% of babies who could not roll over had bruises. Moreover, the pattern, number and distribution of accidental bruises in non-abused children is different to that in those who have been abused. Accidental 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 Patterns of bruising suggestive of physical child abuse include:

- bruising in children who are not independently mobile
- 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
- symmetrical bruising

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.

4. **Scope of Protocol**

4.1 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 worker should be taken as a matter for inquiry and concern.

4.2 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.

4.3 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 P 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 the explanation given.

4.4 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 none mobile. Children who are immobile due to a disability have an increased risk of bruising due to non-accidental injury.

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 go 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.

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. Deciding whether to make a referral

6.1 In not independently mobile children, the presence of any bruising, of any size, in any site should initiate an inquiry into its explanation, origin, characteristics and history. This should be recorded, dated, timed, signed in the child's record and health professionals should also enter in the parent held record (Red Book). The child should then be referred to Children's Social Care.

6.2 It is recognised that a small percentage of bruising in not independently mobile children will have an innocent explanation (including medical causes). Where there is an obvious non-abusive explanation for the bruising or mark such as an immunisation, medical interventions, birth mark or traumatic delivery this referral should not be made. If a referral is not made, the reason must be documented in detail with the names of the professionals making this decision.

6.3 In cases where there is any doubt about the cause of bruising, it is the joint responsibility of Children's Social Care and paediatricians to decide whether the circumstances of the case are consistent with an innocent cause or not and agree a course of action.

6.4 Practitioners should be alert to parental disguised compliance particularly where parents have given a plausible explanation to a previous event and the child represents with the same or a similar pattern of bruising.

6.5 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.
6.6 Practitioners should take into consideration cultural practices and racial characteristics when assessing bruising, including communication difficulties. However no cultural practice should harm a child.

6.7 Blue spots and birth marks should be carefully documented in the health record and parent held record (red book).

6.8 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.

6.9 If in doubt, refer to Appendix 1 for further guidance.

7. Referral to Children’s Social Care

7.1 Referral should, in the first instance, be made by phone:

During office hours (8.30am – 5.00pm Mon – Thurs, 8.30am – 4.30pm Fridays)

B&NES Referral and Assessment (duty) Team 01225 39 6312 / 6313

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

Out of office hours referrals should be made by phoning 01454 615165

7.2 All telephone referrals must be fully documented in the records.

7.3 The referrer should record the joint action plan agreed with Children’s Social Care including any health follow-up.

7.4 All telephone referrals should be followed up in writing with a written referral form (C2) within 48 hours.

8. Referral for a Paediatric Opinion

8.1 When a not independently mobile baby is referred to Children's Social Care under this protocol, a discussion with a paediatrician should follow immediately. This should be undertaken by children’s social care with the community paediatrician on call (Bath NHS House, Newbridge Hill, Bath) or the acute paediatrician team if the child is an inpatient in hospital.

8.2 For a paediatric opinion contact:

During office hours Child Health Department 01225 731575

Out of hours via RUH Switchboard 01225 428331

8.3 The referral should be made, and the child seen, on an urgent and immediate basis.

If necessary a social worker should assist the family to get to the medical consultation.
8.4 The on-call paediatric consultant (or associate specialist) will liaise with Children’s Social Care with regard to the outcome of the assessment as soon as it is completed.

9. Involving Parents or Carers

9.1 As far as possible, parents or carers should be kept fully informed of the process unless to do so would jeopardise information gathering or pose a further risk to the child.

9.2 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 Children's Social Care should be explained to the parents or carers frankly and honestly and the accompanying leaflet should be used to explain the process to parents.

9.3 If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children's Social Care.

9.4 Particular attention should be paid to communication with parents who may have difficulty understanding the explanation, for example parents whose first language is not English or parents with learning difficulties.

10. Sharing Information and Consulting Colleagues

10.1 The case and findings should be shared and discussed with another professional or senior colleague. Child protection issues are necessarily complex and seeking advice from a colleague protects against professional optimism and promotes safe practice.

10.2 In primary care a general practitioner should notify and discuss the findings with the child’s health visitor and vice versa and document the content of this discussion.

10.3 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.

11. History Taking and Examination

11.1 An 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. The parent or carer should be asked when it was first noticed.

11.2 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 concerns about abuse.

12. Assessing the Significance of Bruising

12.1 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 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 (this is by far the most common site of bruising in child abuse)
- Bruising on soft tissues (away from bony prominences) especially cheeks, abdomen, back, buttocks, upper limbs and around eyes
- Multiple bruising especially of uniform shape or symmetrical positions
- Bruises in clusters are common in abused children
- Large bruises
- Bruising around the anus or genitals
- Abusive bruises may carry the Imprint of the implement used or the hand, 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 (dots of blood under the skin) around the bruise are found more commonly in children who have been abused than those injured accidentally
- 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

12.3 Features of innocent bruising:

- Once children are mobile they sustain bruising from everyday activity, fall over or bump into objects in their way. Children have more bruises during the summer months
- 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 centre of their 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.

13. Other Sources of Guidance and Information

Working Together to Safeguard Children, HM Government, 2015

What to Do If You Are Worried a Child Is Being Abused, HM Government, 2015

Child Protection Companion, Royal College of Paediatrics & Child Health, April 2013

When to Suspect Child Maltreatment (NICE Clinical Guideline 89, July 2009)
Bruising in Children – Protocol Summary

The protocol provides frontline and senior staff in the children's workforce 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 unusual marks.

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 before referral to Children’s Social Care.

Bruising is the commonest presenting feature of physical abuse in children. The younger the child the greater the risk that bruising is non-accidental. There is a substantial and well-founded research base on the significance of bruising in children. See Appendix

Any bruising or mark that might be bruising, in a child of any age, that is brought to the attention of a worker should be taken as a matter for inquiry and concern.

Bruising in a non independently mobile child should raise suspicion of maltreatment and should result in an immediate referral to Children’s Social Care and an urgent paediatric opinion. See NICE Clinical Guideline 89: http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English

Where a decision to refer is made, it is the responsibility of the first worker to learn of or observe the bruising to ensure the referral is made.

For Children’s Social Care phone:
B&NES Referral and Assessment (duty team) 01225 39 6312 / 6313
Out of office hours referrals should be made by phoning 01454 615165

All telephone referrals should be followed up within 48 hours with a written referral using a C2 referral form sent to Children's Service, PO Box 25, Riverside, Temple Street, Keynsham, Bristol, BS31 1DN or email ChildCare_duty@bathnes.gov.uk

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 (where appropriate) must be undertaken by a paediatrician.

In NIM children accidental bruising is rare. It is the responsibility of Children's Social Care and the local acute or community paediatrician to decide whether bruising is consistent with an innocent cause or not.

Parents or carers should be kept fully informed of the decision-making process providing this does not pose a further risk to the child. If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be discussed immediately with Children’s Social Care.

Information should be shared between the child’s GP and Health Visitor and health professionals should discuss with a professional or senior colleague such as a member of the Safeguarding Children’s Team Named Nurse or Named Doctor for Child Protection.

The importance of signed, timed, dated, accurate, comprehensive and contemporaneous records cannot be overemphasised.
Joint Bruising Protocol for assessment of bruising in a child who is not independently mobile

Bruise observed on non-mobile child
SUSPECT child maltreatment¹

A child who is seriously ill should go immediately to hospital

Seek an explanation from parent/carer, note size and position of bruise and record accurately

Explain to family the reason for immediate referral to Children’s Social Care

Immediate Phone Referral to Children’s Social Care for multi-agency assessment and information sharing
Follow up with C2 referral form within 48 hours

Social Care to hold strategy discussion to include on call consultant paediatrician (or hospital based paediatrician if child an inpatient)
Agree plan and arrange medical assessment

1. NICE clinical guideline 89: When to suspect child maltreatment, July 2009
   (SUSPECT means serious level of concern about the possibility of child maltreatment but not proof of it)