



## **BRUISING IN PRE-MOBILE BABIES**

### **A PROTOCOL FOR ASSESSMENT, MANAGEMENT AND REFERRAL BY PROFESSIONALS**

#### **KEY MESSAGES:**

- Bruising is the most common presenting feature in physical abuse in children.
- The younger the child the higher the risk that the bruising is non-accidental, especially where the child is under the age of 6 months.
- Bruising in any child 'not independently mobile' should prompt suspicion of maltreatment
- Bruising in any pre-mobile baby should prompt an immediate referral to Social Care, who will arrange an urgent medical examination by a senior paediatrician.

#### **1.0 AIM OF PROTOCOL**

1.1 The aim of this protocol is to provide frontline health and other professionals with a knowledge base and action strategy for the assessment, management and referral of pre-mobile babies who present with bruising or otherwise suspicious marks. (See Section 3.0 below for definitions)

#### **2.0 TARGET AUDIENCE**

2.1 All professionals who may come across bruising to pre-mobile babies.

#### **3.0 DEFINITIONS**

3.1 **Pre-mobile baby:** A baby who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. This includes all babies under the age of six months.

3.2 **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.

#### **4.0 CHILDREN WITH A DISABILITY**

4.1 Consideration should be given to applying this protocol to older children who are not independently mobile by reason of a disability. If in any doubt, professionals should discuss with their safeguarding lead or ring Children's Social Care for a 'what-if discussion'.

## 5.0 INTRODUCTION

5.1 Bruising is the commonest presenting feature of physical abuse in children. 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>)

5.2 In the light of these findings this protocol has been developed for the assessment and management of bruising in pre-mobile babies and the process by which such children should be referred to Children's Social Care, who will ensure a senior paediatrician sees the child for further assessment and investigation of potential child abuse.

5.3 This protocol is necessarily directive. While it recognises that professional judgment and responsibility have to be exercised at all times, it errs on the side of safety by requiring that **all pre-mobile babies with bruising be referred to Children's Social Care and for a senior paediatric opinion where there is no obvious medical cause.**

## 6.0 SCOPE OF THE PROTOCOL

6.1 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 any professional should be taken as a matter for inquiry and concern. This protocol relates only to bruising in pre-mobile babies, that is to say babies who are not yet crawling, shuffling, pulling to stand, cruising or walking independently.

6.2 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.

6.3 It is accepted that marks could be the result of birth trauma, birth marks or areas of skin pigmentation such as 'Mongolian Blue Spots' (see Appendix 1). However if there is any doubt as to the nature of the mark caution should be exercised and this protocol should be followed.

6.4 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.

**6.5 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.**

## 7.0 RESEARCH BASE

7.1 There is a substantial and well-founded research base on the significance of bruising in children  
(See:[http://www.nspcc.org.uk/inform/research/findings/bruisesonchildren\\_wda48277.html](http://www.nspcc.org.uk/inform/research/findings/bruisesonchildren_wda48277.html) ).

7.2 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.

7.3 Research undertaken in Wales indicates that severe child abuse is six times more common in babies aged under one year than in children aged one to 4 years, and 120 times more likely than in the 5 – 13 year old age group. This research also showed that, of the abused babies aged under one year, 30% had caused previous concern to health professionals in relation to abuse or neglect.

7.4 Further research into child deaths from non-accidental injuries and children who suffer serious injury suggests that these children often have a history of minor injuries prior to hospital admission.

7.5 On average, the under ones are seven times more likely to be killed than older children in England and Wales (NSPCC, March 2013: See: [http://www.nspcc.org.uk/Inform/research/statistics/child\\_homicide\\_statistics\\_wda48747.html](http://www.nspcc.org.uk/Inform/research/statistics/child_homicide_statistics_wda48747.html) )

## **8.0 EMERGENCY ADMISSION TO HOSPITAL**

8.1 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.

8.2 Occasionally spontaneous bruising may occur as a result of a medication 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.**

8.3 A referral to hospital under the above circumstance 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.**

8.4 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.

## **9.0 REFERRAL TO CHILDREN'S SOCIAL CARE**

**9.1 The presence of any bruising in pre-mobile babies of any size, in any site, should initiate a detailed examination and inquiry into its explanation, origin, characteristics and history. The child should then be referred to Children's Social Care.** The contact numbers are available at Appendix 2.

9.2 A referral to Children's Social Care **must be made as soon as possible.**

Never delay emergency action to protect a child.

9.3 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.**

9.4 The decision to refer may be undertaken jointly with another professional or senior colleague. However this discussion should not delay an individual professional of any status referring to Children's Services any child with bruising who, in their judgement, may be at risk of child abuse.

9.5 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, especially a very young child who will be particularly vulnerable.

9.6 Children's Social Care (CSC) will take any referral made under this protocol as requiring further multi-agency investigation. CSC will initiate Section 47 enquiries if needed and will involve all appropriate agencies such as police as per protocol. CSC will contact the Paediatrician to whom referral is also made under section 10 below for a medical opinion before reaching any final conclusions on the case.

9.7 All telephone referrals must be followed up within 48 hours with a written referral.

## **10.0 REFERRAL FOR A PAEDIATRIC OPINION BY SOCIAL CARE**

10.1 Once a referral has been made to Children's Social Care, **Social Care will take responsibility for making a referral to the paediatric services.** The contact numbers are available in Appendix 3.

10.2 **The referral should be made, and the child seen, on an urgent and immediate basis.** Wherever possible, a member of staff from Children's Services should accompany the family at the assessment.

10.3 The relevant paediatrician **must** liaise with Children's Social Care with regard to the outcome of the assessment as soon as it is completed.

10.4 Where a referral is delayed for any reason, or where bruising is no longer visible, a senior paediatrician must still examine the child to assess, as a minimum, general health, signs of other injuries or pointers to maltreatment, and to exclude bleeding disorders.

## **11.0 INNOCENT BRUISING**

11.1 It is recognised that a small percentage of bruising in pre-mobile babies will have an innocent explanation (including medical causes). Nevertheless, because of the difficulty in excluding non-accidental injury, practitioners should refer to Children's Social Care.

11.2 It is the responsibility of Children's Social Care, in conjunction with the local acute or community paediatric department, to decide whether the circumstances

of the case and the explanation for the injury are consistent with an innocent cause or not.

11.3 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. One would **not** expect such 'innocent' bruising in pre-mobile babies.

11.4 In general practice, any history of bruising should be flagged as a significant problem/risk factor in the notes.

## **12.0 ASSESSMENT AND RISK**

**12.1 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.**

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

12.3 Bruising which might be indicative of abuse include:

- 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
- Bruising caused by an object or implement may not always show a typical imprint of the injuring object
- In some areas of the body, such as the cleft of the buttocks and the ears.
- 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 children with a disability

## **13.0 DOCUMENTATION**

**13.1 The importance of signed, timed, accurate comprehensive contemporaneous records cannot be over-emphasised.**

13.2 As part of the paediatric assessment, it is good practice to photograph any visible injuries. Ideally these photographs will be taken by the medical photography department following a request by the clinician examining the child.

## **14.0 WORKING IN PARTNERSHIP WITH PARENTS OR CARERS**

14.1 Unless it is considered that this would place the child at further risk, the professional's concerns should be discussed with parents or carers of the child at the time they arise/occur, taking care that the professional does not suggest to the parents/carers how the injury has occurred.

14.2 The child's parents or carers should be informed of any intention to make a referral to Children's Social Care – unless it is considered that this would place the child at further risk.

14.3 If the child's parents/carers are not aware of the referral, this **must** be made clear to Children's Social Care.

14.4 If a parent or carer is uncooperative or refuses to take the child for further assessment, this **must** be reported to Children's Social Care. If possible, the child should be kept under supervision until steps can be taken to secure his or her safety.

## **15.0 CONFIDENTIALITY**

15.1 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 the belief that a child may be suffering, or be at risk of suffering, significant harm. (*Working Together to Safeguard Children 2010*)

## **16.0 THE WELFARE OF THE CHILD IS PARAMOUNT (Children Act 1989)**

The Child's welfare is paramount and safeguarding and promoting it is the priority. Lord Justice Elizabeth Butler-Sloss in the Court of Appeal stated that where there is a conflict of interest between the rights and interests of a child and those of a parent, the interests of the child had to prevail under Article 8 (2) of the European Convention.

## APPENDIX 1

### Congenital dermal melanocytosis (Mongolian Blue Spots)

**These birthmarks can sometimes be mistaken for bruises and raise questions about child abuse.**

Mongolian blue spots also known as congenital dermal melanocytosis are flat bluish or bluish-grey skin markings that commonly appear on babies at birth or shortly thereafter.

They are particularly common among darker-skinned children, such as Asian, African and those from mixed-race parentage.

The spots appear as dark blue lesions with unclear borders and irregular shapes. They can normally be found at the base of the spine, on the buttocks and back but they have been known to appear on other areas of the body such as the face, arms and shoulders.

Occasionally, Mongolian blue spots are mistaken for bruises and questions about child abuse arise. It is important to recognise that Mongolian blue spots are birthmarks, NOT bruises. For this reason, **it is clearly important to document the presence of these spots on the area of the body in the Child Health record (Red Book).**

Most health workers are now aware of the markings and questions of child abuse should not arise. When there is a dilemma in the diagnosis of the marks, please discuss with the GP to verify and confirm the diagnosis. Examination of the skin is sufficient to determine that the marked areas are Mongolian blue spots. No testing is necessary. If the GP is unsure, he/she can contact the Paediatric team accordingly.



## APPENDIX 2

### SOCIAL CARE CONTACT DETAILS

#### **PETERBOROUGH:**

Referrals should, in the first instance, be made by telephone to:  
Peterborough Children's Services Referral and Assessment Team  
Telephone no.: **01733 864170 / 864180**  
Open from 9 a.m. to 5 p.m. from Monday to Friday.

Out of Hours: Referrals should be made to the Emergency Duty Team on  
**01733 234724**

#### **CAMBRIDGESHIRE:**

Referrals should, in the first instance, be made by telephone to:  
Cambridgeshire Direct  
Telephone no.: **0345 045 5203**  
Open from 8 a.m. to 6 p.m. from Monday to Friday.

Out of Hours: Referrals should be made to the Emergency Duty Team on  
**01733 234724**



## APPENDIX 3

### PAEDIATRIC SERVICE CONTACT DETAILS

#### **PETERBOROUGH:**

Ring Peterborough City Hospital on 01733 678000 and ask to speak with the Paediatric Doctor on call. The out of hours emergency service is available through the Senior Paediatrician on call at Peterborough City Hospital.

#### **CAMBRIDGESHIRE:**

##### **CAMBRIDGE EAST, CITY& SOUTH AREA**

###### **DURING WORKING HOURS: (9am – 5pm weekdays)**

Please discuss with On call Community Paediatrician on **01223 884160**

###### **OUT OF HOURS:**

Children for urgent assessment to be referred to the On call Paediatric team at Addenbrookes Hospital, Cambridge Switchboard on **01223 245151**

##### **HUNTINGDONSHIRE & FENLAND AREA**

###### **DURING WORKING HOURS: (9am – 5pm weekdays)**

Please contact the Consultant of the Week Paediatrician at Hinchingsbrooke Hospital Switchboard on **01480 416416**

###### **OUT OF HOURS:**

**Huntingdonshire area:** Contact On-call Paediatric Registrar at Hinchingsbrooke Hospital on **01480 416416** who will discuss with the On call Consultant Paediatrician

**Fenland area:** Children to be referred to the On call Paediatric Team at Queen Elizabeth Hospital at Kings Lynn on **01553 613613**