SOUTHEND, ESSEX AND THURROCK
MULTI-AGENCY PROTOCOL

Management of Suspicious, Unexplained Injuries or Bruising in Children for all Frontline Practitioners

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Contents

1. Introduction

1.1 Purpose of the guidance

This guidance provides an overview of suspicious and unexplained injuries in pre-mobile and mobile infants and children and outlines the pathways practitioners and individual agencies are expected to follow when concerns are identified. The guidance should be read in conjunction with the Southend, Essex, and Thurrock (SET) Safeguarding and Child Protection Procedures.

1.2 Who this guidance is for?

This guidance applies to all those who may come into contact with infants and children in their everyday duties and the actions they are expected to initiate in accordance with their responsibilities, as outlined within Working Together to Safeguard Children (2018).

2. Non-accidental injuries and bruising

2.1 Bruising and physical abuse

Bruising is the most common injury to a child who has been physically abused. It is therefore vital to differentiate accidental from non-accidental bruises and other suspicious injuries, and to avoid common assumptions about such injuries which cannot be substantiated. The possibility of child maltreatment or neglect must inform a differential diagnosis until there is sufficient evidence to prove otherwise.

2.2 Non-accidental injuries

Non-accidental injuries are injuries that are suspected or proven to have been inflicted upon an infant or child by someone else, or in the care of someone else. Any bruising, fractures, bleeding, and any other injuries (such as burns) should be treated as a matter for enquiry and potential abuse considered, unless otherwise evidenced.

2.3 Bruising and neglect

Bruising, though the most common presenting feature of physical abuse in children, may also be as the result of the child experiencing other forms of abuse such as neglect or sexual abuse. Child Safeguarding Practice Reviews nationally and locally across Southend, Essex, and Thurrock (SET) highlight how practitioners underestimate the prediction that abuse is a likely cause of bruising, particularly in young babies.

2.4 NICE guidance

NICE guidance (2009, updated 2017) states that bruising in any infant or child who is not independently mobile should prompt suspicion of maltreatment as these infants and children are the least likely to sustain accidental bruises.
If at any time you are unsure what action to take, then consult your line manager or designated safeguarding lead.

3. Underpinning Research on Bruising

3.1 Key findings from two Royal College of Paediatrics and Child Health

Key findings from two Royal College of Paediatrics and Child Health (RCPCH, 2020a; RCPCH, 2020b) systematic reviews evidence that:

- Bruising was the most common injury in children who have been abused and a common injury in non-abused children, the exception to this being in pre-mobile infants where accidental bruising is rare (<1%)
- Bruising can be viewed as a common presentation in children; however, this should trigger professional curiosity to exclude more severe underlying injuries.
- This highlights the importance of recognition of abnormal patterns of bruising in young infants, enabling detection as early as possible and potentially preventing escalation of abuse with avoidance of serious injury or death.
- In a study of 77 infants with abusive fractures, 32% had missed opportunities for the diagnosis of child abuse. The most common sign on examination was bruising or swelling.
- In another study of 146 infants less than six months of age presenting to child abuse physicians with an isolated bruise, 23.3% had skull fractures identified on skeletal survey.
- Absence of abdominal bruising does not rule out a significant abdominal injury just as the absence of bruising does not preclude Abusive Head Trauma (AHT) (RCPCH, 2019)

A bruise must never be interpreted in isolation. It must always be assessed in the context of medical and social history, developmental stage, explanation given, full clinical examination and relevant investigations. If at any point you are unsure on the action to take, consult your line manager or designated safeguarding lead.

Characteristics of bruising that are suggestive of physical abuse:

- Bruising in children who are not independently mobile
- Bruises that are seen away from bony prominences (i.e., areas of bone that are close to the skin surface)
- Bruises to the face, abdomen, arms, buttocks, genitalia, ears, neck, and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of an implement used and/or a ligature
- Bruises that are accompanied by petechiae (tiny dots of blood under the skin), in the absence of underlying bleeding disorders
- Petechiae (tiny dots of blood under the skin), in the absence of bruising may occur as a consequence of suffocation
- Petechiae (tiny dots of blood under the skin), are located on the skin of the face and throat, the upper chest, the shoulders and inside the mouth

3.2 Can a bruise be accurately aged?

- The scientific evidence concludes that a bruise cannot be accurately aged from clinical assessment or from a photograph.

- Any clinician who offers a definitive estimate of the age of a bruise in a child by assessment with the naked eye is doing so without adequate published evidence.

3.3 If you have no concerns

If there is agreement that the history given is consistent with the bruise/mark/injury observed, the infant/child's developmental age, and mobility, ensure you:

- Review all previous records for any similar history or risk factors.
- Document all observations and what has been reported by the infant/child and parent/carer/s within clinical records.
- Document clearly bruising/marks observed on a body map (Appendix 1) and record in the infant/child's Parent Held Record.
- Consider safety assessment and advice to prevent further incident/s.
- Share relevant information with Health Visiting/School Nursing Service, GP or any other relevant agency.

4. Non-accidental injuries and bruising in pre-mobile/non-mobile children

4.1 Unexplained or suspicious injuries

Unexplained or suspicious injuries in pre-mobile infants and non-independently mobile children. Any injuries are unusual in this age group, unless accompanied by a full consistent explanation. Even small injuries may be significant, and they may be a sign that another hidden injury is already present.

Such injuries include:

- Small single bruises e.g., on face, cheeks, ears, chest, arms or legs, hands or feet or trunk
- Bruised lip or torn frenulum (small area of skin between the inside of the upper and lower lip and gum)
- Lacerations, abrasions, scratches, or scars
- Burns and scalds
- Pain, tenderness or failing to use an arm or leg which may indicate an underlying fracture
- Small bleeds into the whites of the eyes or other eye injuries

4.2 Other harms

Occasionally an infant can be harmed in other ways, for example:

- Deliberate poisoning
- Suffocation which can present as collapse, absence of breathing (apnoeic attack), bleeding from the mouth and nose
- Accidental ingestion of prescribed medication or illicit drugs

4.3 Clinical assessment

A full clinical assessment and relevant investigation must be undertaken at the earliest opportunity and should include the:

- Nature and site of injury
- History provided by accompanying adult
- Plausibility of the explanation given
- Timing/age of the alleged injury and any delay in seeking medical attention for which there is no satisfactory explanation
- Infant/child's appearance, behaviour, and demeanor
- Infant/child's development
- Interaction between parent/s, carer/s, and infant/child
- Family and social circumstances and other relevant information available on the infant/child's records

An explanation for an injury or presentation must be questioned if implausible, inadequate, or inconsistent:

- With the infant/child's presentation, normal activities, existing medical condition, age, or developmental stage, when compared to the account given by parent/carer/s
- Between parent/s or carer/s
- Accounts differing in details over time
- If no explanation can be given by the parent or carer
- Based on cultural practice

If you are unsure on what action to take, consult your line manager or designated safeguarding lead.

4.4 Birth marks

Congenital dermal melanocytosis (flat blue-grey skin marking) and strawberry marks or haemangioma are present at birth or appear in the first few days of life and can be seen anywhere on the body. These should be recorded in the infant's health records, parental held child's health record ('red book') and body map.
If a practitioner is unsure regarding whether a mark is a birthmark, then the child should be reviewed by a doctor to confirm this. (see section 7.4 'Diversity factors')

4.5 Actions required when a suspicious injury is identified

Life threatening emergency medical condition or injury

Any infant/child with suspicious bruises or marks ***and*** is seriously ill or injured, or in need of urgent treatment should be immediately referred to hospital.

Do not delay call 999 request an emergency ambulance and consider requesting police attendance if appropriate.

Non-life-threatening condition or injury

It is the responsibility of the practitioner who identifies the suspicious mark/injury on the child to:

- Contact their safeguarding lead to discuss and agree actions to be taken

- The Paediatrician at the nearest Emergency Department is contacted to inform of the concerns/all known information shared ahead of attendance of infant/child (see Flowchart at 4.7)
- Transportation available for the transfer of the infant/child to hospital:
    - consider transfer by ambulance in all situations
    - non-life-threatening emergency: are parent/s or carer/s able to take their infant/child to hospital unaccompanied by a practitioner – ***is this a safe option?***

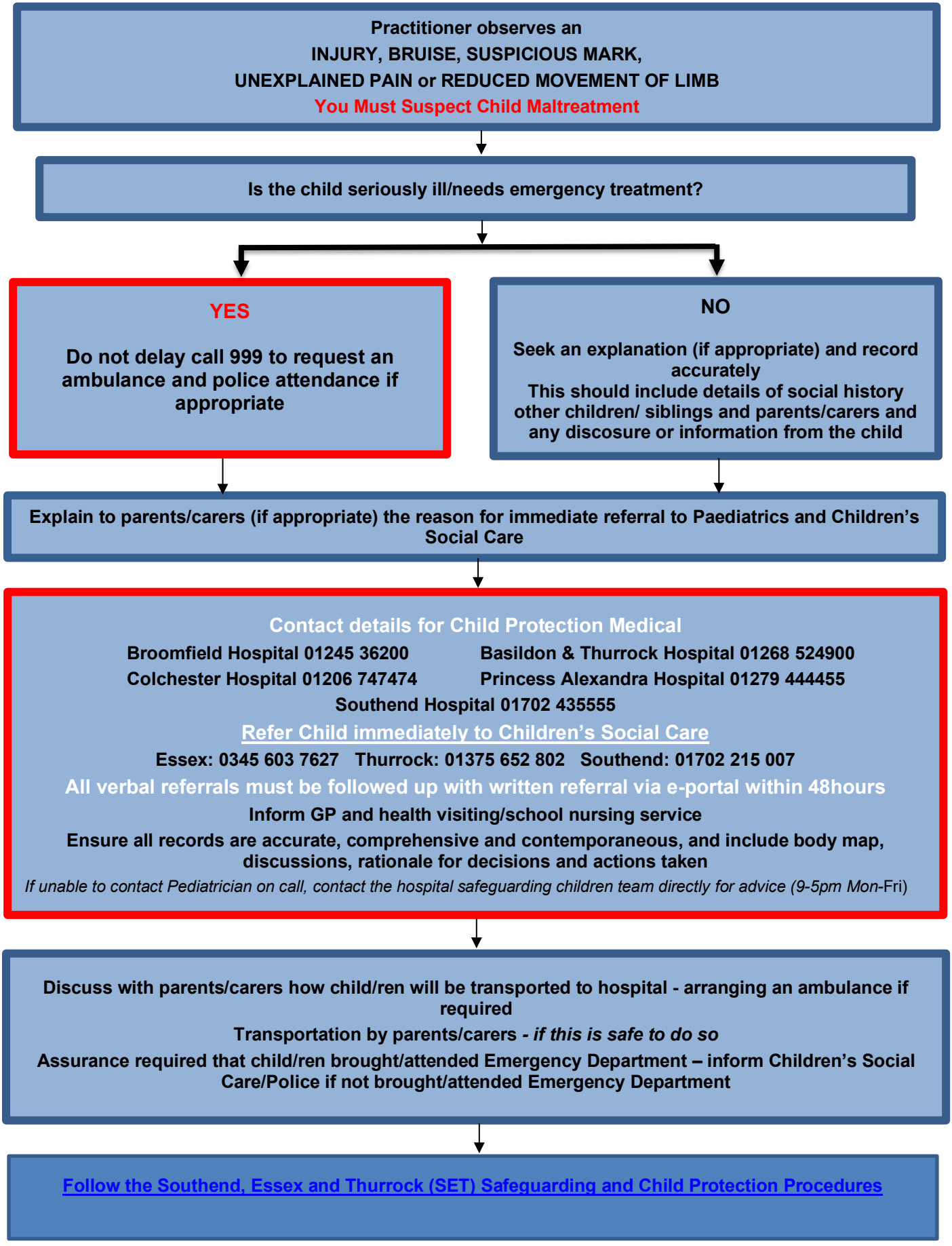
It is the responsibility of the referring and receiving practitioners to agree arrangements confirming the following:

- Referral to Children's Social Care has been completed by the person who identified the concerns (see Appendix 2)
- If the infant/child is not taken by parent/s or carer/s to Emergency Department: immediate escalation to Children's Social Care and Police
- Practitioners to be transparent with parents/carer/s explaining reasons for referral to Children's Social Care and for a medical assessment

4.6 Request support from Children's Social Care

In pre-mobile infants and non-independently mobile children the presence of any bruising of any size and in any site requires immediate referral to Children's Social Care and consideration may be given to contacting the Police.

4.7 Flowchart for Injury, Bruise, Suspicious Mark, Unexplained Pain or Reduced Movement of Limb for pre-mobile infant or non-independently mobile child



5. Injury, Bruise, Suspicious Mark, Unexplained Pain or Reduced Movement of Limb in mobile children

- Bruising appropriate to learning to walk is common when most children have started 'cruising'. It is typically distributed on the front of legs/below knee and the knee, followed by the upper legs and forehead
- A pattern of bruising may indicate physical abuse has taken place; clusters of bruises are a common feature in abused children
- Bruises often occur on soft parts of the body such as the abdomen, back and buttocks
- The head is by far the commonest site of bruising in child abuse, other common sites include the ear and the neck
- As a result of defending themselves, abused children may have bruising on the forearm, upper arm, back of the leg, hands, or feet
- Bruises can often carry the imprint of the implement used or the hand
- Non-accidental head injury or fractures can occur without bruising
- Severe bruising to the scalp, with swelling around the eyes and no skull fracture may occur if the child has been "scalped" – i.e. had their hair pulled violently
- Genital bruising could indicate child sexual abuse (NSPCC, 2021). Where child sexual abuse is suspected then the local Sexual Assault Referral Centre (SARC) pathway should be followed.

5.1 Actions required when a suspicious injury is identified for a child

Life threatening emergency medical condition or injury

Any infant/child with suspicious bruises or marks ***and*** is seriously ill or injured, or in need of urgent treatment should be immediately referred to hospital

Do not delay call 999 request an emergency ambulance and consider requesting police attendance if appropriate

Non-life-threatening condition or injury

Contact their safeguarding lead to discuss and agree actions to be taken

Request support from Children's Social Care:

- The presence of suspicious marks or bruising without a clear and consistent explanation or, a disclosure made by child/ren, requires an immediate referral to Children's Social Care
- Practitioners should ensure that they have sufficient information to assist Children's Social Care in responding to their concerns including any other relevant background information that is known to referring agency

It is good practice to inform the parent/s or carer/s that a referral will be made to Children's Social Care, unless this places the child/ren at greater risk.

5.2 Flowchart for Injury, Bruise, Suspicious Mark, Unexplained Pain or Reduced Movement of Limb in a mobile child

6. Multi-agency response for all referrals

6.1 Children's Social Care

Children's Social Care will consider any referral made under this protocol in line with normal safeguarding practice

For non-mobile children with suspicious injury or bruising a strategy meeting will be convened to determine whether there is a risk of significant harm to the child.

For mobile children social care will

- Assess the level of risk
- Consideration of a Strategy Meeting if the threshold for significant harm is met
- Consideration whether to undertake a Child Protection Medical

Child Protection Medical *not* required: Social Worker should consider the medical needs of the infant/child, following discussion with relevant health practitioners, and ascertain whether a medical assessment is still required.

Delayed Child Protection Medical (for any reason), bruising /mark is no longer visible, a Paediatrician to examine the child/ren to assess general health, signs of other injuries or maltreatment and to exclude any medical cause. Outcomes to be shared with Social Worker.

6.2 Police – for all referrals

The Police on receipt of a referral made under this protocol will consider:

- To conduct a review to consider the need for any immediate safeguarding measures to be implemented in order to safeguard the infant/child involved
- Undertake further multi-agency investigation including -
    - Notify partner organisations of the referral and the requirement for strategy meeting to be convened
    - Collate all available information to share during attendance at strategy meeting
    - Undertake such actions to ensure the safety of ***all identified infants and child/ren*** and if deemed appropriate secure and preserve evidence in accordance with legislation and best practice

7. Wider considerations

7.1 When should parent/s and carer/s be informed

Parent/s and carer/s to be informed at an early stage of:

- Progress of decision-making process and reasons for this - unless to do so will further jeopardise information gathering or pose further risk to the infant/child
- This process is to be carried out sensitively and in a private place to avoid further distress to parent/s or carer/s

7.2 Educational setting

If an education setting observes a child/ren with suspicious marks or bruises or a child discloses physical abuse, the education setting should enquire with the child how it happened and then contact the appropriate local authority.

- Essex County Council Children & Families Hub by calling 0345 603 7627 and asking for the consultation line.
- Southend Multi-agency Safeguarding Hub (MASH) on 01702215007
- Thurrock Multi-agency Safeguarding Hub (MASH) on 01375 652 802.

The Essex County Council Children & Families Hub or Southend or Thurrock Multi-agency Safeguarding Hub (MASH) will then advise on how to proceed, whether the concerns reach the threshold for a request for support to be submitted and whether to speak with the parents/carer/s prior to taking any further action.

7.3 Children with disabilities

Children with disabilities are at increased risk of suffering maltreatment therefore practitioners should ensure:

- Effective communication – awareness of need to identify assistance that is required to support the infant/child (e.g., Makaton, British sign language, braille)
- Inability to speak, read or write English – practitioners to seek assistance of independent interpreter
- Disability should not hinder the assessment of suspicious marks or bruises on infant/child
- Health practitioners should contact the learning disabilities nurse /safeguarding team if further advice or support is required
- The child's presentation should be taken into account when assessing any injuries sustained or bruising. This is to determine whether there is a pattern of injuries or bruising which could be considered as neglectful or abusive or if they are directly related to their individual disability.

7.4 Diversity factors

- Consideration should be given to the cultural needs of infant/child, young people, parent/s, family, and carer/s. However, cultural practices that are abusive are not acceptable reasons for child maltreatment
- The assessment should consider the infant/child's skin colour and how this may influence the clinical assessment (Mukwende, 2020)
- Practitioners should at all times be aware of, and sensitive to, any difficulties in

communicating this protocol to the infant/child, parent/s, or carer/s. This may be due to learning difficulty/disability, language barriers (including the need for an independent interpreter) or lack of awareness/knowledge of UK legislation

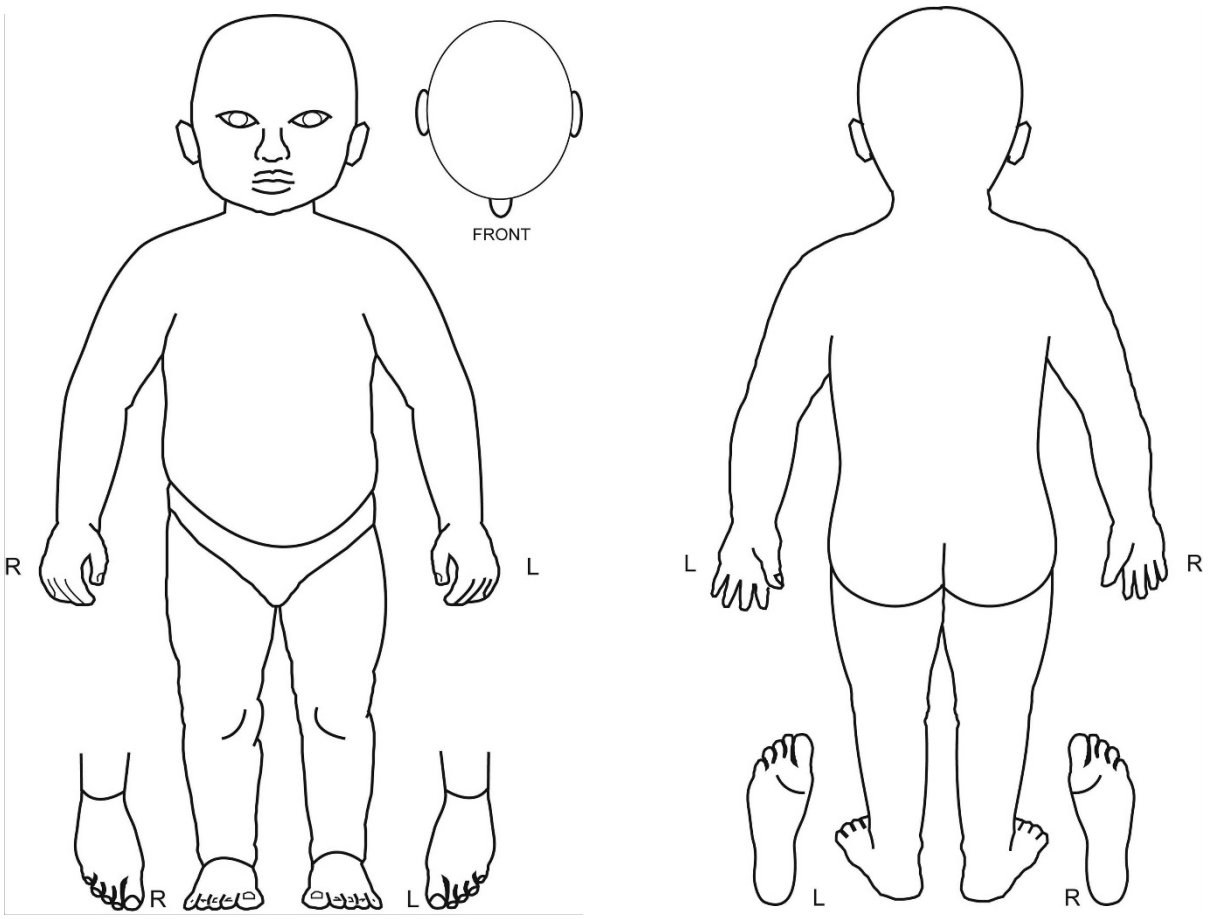
- It is important that the child/ren are seen promptly with the required provision to assist effective communication and this should not delay immediate referral.

8. Escalation process

If you are concerned about the lack of response to a safeguarding concern from any agency, discuss with your Safeguarding Lead/Line Manager who will assist to review own agency Safeguarding /Child Protection procedure/s escalation process with the support of the SET Safeguarding and Child Protection Procedures.

Appendix 1: Body Map

Child's name:	
Date of birth:	
Date/time skin markings/ injuries observed:	
Who injuries observed by:	
Information recorded:	
Date:	
Time:	
Name:	
Signature:	



Appendix 2: Contacts

Contacting Paediatrician at nearest Emergency Departments

Hospital	Contact numbers
Basildon & Thurrock University Hospital	01268 524900
Broomfield Hospital, Chelmsford	01245 362000
Colchester Hospital	01206 747474
Princess Alexandra Hospital, Harlow	01279 444455
Southend Hospital	01702 435555

Community Referral for a Child Protection Medical

Hospital/ Community Services	Contact numbers
Basildon, Brentwood & Thurrock localities	nem-tr.cpsafeguarding@nhs.net
Broomfield Hospital, Chelmsford	01245 362000
Colchester Hospital	01206 747474
Princess Alexandra Hospital, Harlow	Contact either 01279978288 or 01279962644 Or PAH Switchboard
Southend Hospital	01702 435555

Links to Children's Social Care

Essex	Children & Families Hub 0345 603 7627 Essex (Request for Support online portal): Report a concern about a child: Report a concern about a child - Essex County Council
Thurrock	01375 652 802 Thurrock (CAF submitted to Thurrock MASH): https://www.thurrock.gov.uk/childrens-care-professionals-processes/referral-pathways-and-services
Southend	MASH: 01702 215 007 https://www.southend.gov.uk/childrens-social-care/child-protection

	All verbal referrals must be followed up with written referral within 48hours

Appendix 3: References

Essex Safeguarding Children Board (ESCB) (2021) Southend, Essex and Thurrock (SET) Child Protection and Safeguarding Procedures
Home (escb.co.uk)

HM Government (2018) Working Together to Safeguard Children
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

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https://www.nice.org.uk/guidance/CG89

NSPCC (2021) Sexual abuse Available at: https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-abuse/

The Royal College of Paediatrics and Child Health (RCPCH) (2019) Abusive Head Trauma
https://www.rcpch.ac.uk/sites/default/files/2021-02/Child%20Protection%20Evidence%20-%20Head%20and%20spinal%20injuries.pdf

The Royal College of Paediatrics and Child Health (RCPCH) (2020a) Child Protection Evidence: Systematic review on Bruising
https://www.rcpch.ac.uk/sites/default/files/2021-02/Child%20Protection%20Evidence-%20Chapter%20Bruising_Update_final.pdf

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https://www.rcpch.ac.uk/sites/default/files/202010/Chapter%20Fractures_Update_280920.pdf