NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

NON-MOBILE BABIES AND CHILDREN – PROCEDURES FOR ASSESSMENT OF INJURIES

Acknowledgement: NEL LSCB would like to thank Wakefield and District Safeguarding Children Board.

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1. INTRODUCTION – GUIDING PRINCIPLES

This protocol has been agreed by all partner agencies of the North East Lincolnshire Safeguarding Children Board.

The protocol is relevant to any practitioner operating within the North East Lincolnshire who may come into contact with babies (or children) who are not yet self-mobile and who may be in a position to identify that such a child has received an actual or suspected bruise, burn or scald (as defined in Section 2, Definitions on Burns).

This protocol must also apply to all circumstances where a non-mobile baby is seen with injuries irrespective of the status of carers, e.g. baby/child cared for in a professional setting, or child in the care of a Local Authority.

Bruising is the most common accidental injury experienced by children, and research shows that the likelihood of a baby sustaining accidental bruising increases with increased mobility. The evidence suggests that it is extremely rare for a non-mobile baby, for example one that is not yet crawling, to sustain accidental bruising or injuries.

A bruise or an injury must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. Therefore, all such bruising should be **suspected** by practitioners to be an indicator of physical abuse and **thoroughly explored**.

It should also be borne in mind that other unusual marks on the skin or unusual sites of bleeding e.g. bleeding from the mouth in young children without a clear explanation may also be a sign of non-accidental injury and should also be considered in line with this protocol.

It is recognised that a small percentage of bruising in non-independently mobile babies and children will have an innocent explanation (including medical causes). However, practitioners should not make decisions in isolation, due to the difficulty in excluding non-accidental injury.

Published evidence suggests that children under the age of three, and particularly those under one year, are most at risk of suffering physical abuse. However, practitioners are reminded that all children are vulnerable to harm and as such practitioners should remain alert to signs of abuse, unexplained or unusual injuries; or injuries where the explanation provided is not congruent with the injury sustained.

A decision that the child has not suffered abuse must be a joint decision and must not be made by an individual.

2. DEFINITIONS

NON-MOBILE: This includes children who are not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Includes all children under the age of 6 month.

*Please note that some babies can roll from a very early age and this **does not** constitute self-mobility.*

BRUISING: Bruising is caused by leakage of blood into the surrounding soft tissues, producing a temporary 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 spots, less than two millimetres in diameter and often presenting in clusters.

SUBCONJUNCTIVAL HAEMORRHAGES: refer to bleeding within the whites of the eyes and should be considered as similar to bruising to the eye itself for the purposes of this protocol.

Bruising to very young babies may be caused by medical issues e.g. birth trauma, however this is rare. In addition, some medical conditions can cause marks to the skin in very young babies that may resemble a bruise. 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. The younger the child the greater the risk that bruising is non-accidental and the greater potential risk. In all cases, unless the specific mark that has been identified is confirmed as arising from a medical condition, this protocol should be followed to enable multi-agency assessment of the suspected bruise.

BURN: Damage to the skin or other body parts caused by extreme heat, flame, contact with heated objects, or chemicals. Burn depth is generally categorized as first, second, or third degree.

SCALD: Tissue damage caused by applied wet heat such as hot water or steam.

FRACTURE: A fracture is a medical condition in which there is a break in the continuity of the bone. This may be as a result of high impact force or stress, or a minimal trauma injury as a result of certain medical conditions that weaken the bones.

3. SCOPE OF PROTOCOL

This protocol must be followed in all situations where an injury is noted in a baby or child who is not independently mobile.

This protocol requires that all actual or suspected injuries to babies who are non-mobile should be subject to further enquiry in order to assess the risk of harm. For this reason, any practitioner who identifies such an injury to a non-mobile baby or child may be required to make a referral to the children's social care department via Multi-agency Safeguarding Hub, dependent on the explanation offered by parents or carers, and any decision made by the identifying practitioner in consultation with another professional about how the injury may have been caused.

BRUISING IN CHILDREN OF ANY AGE

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 practitioner should be taken as a matter for enquiry. A satisfactory explanation should be sought and the characteristics of the bruising should be assessed, the distribution carefully recorded. The bruising should be assessed in the context of personal, family and environmental history to ensure that it is consistent with an innocent explanation.

Patterns and examples of common sites for accidental and non-accidental bruising can be found at **Appendix C: Common sites of accidental and non-accidental bruising.**

BIRTH INJURY

Both normal births and instrumental delivery may lead to development of bruising and of minor bleeding into the eye. However practitioners should be alert to the possibility of physical abuse and follow this policy if there is any doubt about the features seen. Any injuries believed to be as a result of delivery including fractures, bruising or bleeding into the eye during birth, and any procedures undertaken during, or after delivery which may have led to injuries **MUST** be documented in professional records, to allow for comparative assessment. The use of Body Maps to record the site and specifics of injuries should be used routinely.

BIRTHMARKS

Birthmarks may be present at birth and can also appear in the early weeks and months. Certain birthmarks, particularly Mongolian blue spots can mimic bruising. Birthmarks, in particular Mongolian blue spots, **MUST** be documented in professional records.

SELF-INFLICTED INJURY

It is rare for a non-mobile infant to cause any significant self-inflicted injury during normal activity. It is not uncommon, for a baby to cause small superficial scratches, particularly to their face, and rarely to the surface of an eye. However, these scratches are very narrow, and heal very quickly. Any scratch to the surface of the eye does not cause bleeding beyond the site of the scratch. Any explanation that any injury, barring a small scratch, is self-inflicted should not be accepted.

INJURY FROM OTHER CHILDREN

Explanations that a sibling has caused the injury should still be further explored, which must include a detailed history of the circumstances of the injury and consideration of the parent's ability to supervise their children.

SUBCONJUNCTIVAL HAEMORRHAGE

Any baby who develops a subconjunctival haemorrhage which is not birth related, or where there is no obvious other cause, should be assessed by a paediatrician.

CHILDREN WITH DISABILITIES

Immobility in older children should be taken into account as a risk factor, for example in disabled or very sick children. Disabled children have a higher incidence of abuse whether mobile or not.

IDENTIFICATION OF NON- ACCIDENTAL INJURIES

It is not always easy to identify with certainty that a skin mark is 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.

Children may be abused (including sustaining fractures, serious head injuries and intra-abdominal injuries) with no evidence of bruising or external injury.

*'Rough handling' is never an acceptable reason for an injury and **MUST NOT** be accepted as a 'reasonable explanation'*.

4. ACTION TO BE TAKEN

Where a practitioner identifies a non-mobile baby or child with an injury, the practitioner should seek an explanation from parent or carer, or child if possible.

The identifying practitioner must discuss the injury and explanation with a senior colleague, either within their own service/ agency or in a partner agency. The identifying practitioner and/or colleague should consider seeking advice from a qualified health professional or safeguarding lead if further support is required.

A joint decision is made between the two practitioners/ professionals as to whether the explanation for the injury is suitable, and whether a referral is required to children's social care.

If the infant appears ill or seriously injured seek emergency treatment and notify children's services of your concerns.

- In all cases, contemporaneous, comprehensive, accurate, dated timed records should be kept. In all cases mapping, description and recording of the size, colour, characteristics of injuries, including site pattern and number of bruises should be made on a body diagram. Carefully record what was seen using a body map or line drawing if appropriate (See **Appendix A: Body Maps**). A careful record of carers/parents description of events and explanation for the injury should be made in the notes;
- If a referral is deemed necessary, make a referral to children's services following usual processes. They will take responsibility for further multi-agency investigation including paediatric assessment;
- Information **MUST** be shared with the child's GP and Health Visitor (for children under 5) and the referral should be discussed with the practitioner's child protection lead.

Any referral is the responsibility of the first practitioner to be made aware of, or observe the injury.

5. REFERRING THE CHILD TO FAMILIES FIRST ACCESS POINT (FFAP)

This protocol requires any practitioner who identifies an actual or suspected injury to consider the need to make a referral to Families First Access Point (FFAP). This is because there is a significant possibility that such injury in a non-mobile baby may have arisen as a result of abuse or neglect.

The referrer should treat the Families First Access Point as the first point of contact, as the service that deals with all requests for a children's social care service, including concerns related to child abuse and neglect.

North East Lincolnshire Families First Access Point (FFAP) can be contacted on 01472 326292.

6. INFORMING THE PARENTS/CARERS AND OBTAINING CONSENT

It would be expected that in most cases the practitioner will inform a parent/carer of their intention to make a referral and obtain their consent. However, in judging whether or not to inform the parent/carer that a referral is to be made, the practitioner who has identified the suspected injury must consider the possibility that to do so may increase the level of risk to the baby. In this instance the practitioner does not need to obtain consent to make a referral. If the parent or carer is uncooperative or refuses to take the child for further assessment this should be reported to Children's Services.

If the practitioner concludes that informing the parent/carer may increase the level of risk to the baby, they should consult with Families First Access Point or the child's allocated Social Worker before speaking to the parent in order to obtain advice.

In all cases, Families First Access Point must be advised if the parents or carers are aware of the referral.

Prior to making the referral, the practitioner should ensure that they have sufficient information. This would include basic details such as name, date of birth, address, contact telephone number etc. as well as details of parents/carers and any other relevant background information that is known at the time.

Upon identifying a concern, there should be no delay in making a referral to Families First Access Point.

See Section 6, Informing the Parents/Carers and Obtaining Consent for further detail regarding consent.

See also: Responding to Abuse and Neglect.

7. ACTION TO BE TAKEN BY CHILDREN'S SOCIAL CARE

Referrals made to Children's Social Care under this protocol will always be deemed to be high priority due to the vulnerability of the child concerned.

The action following a referral, during normal working hours or out of hours, to Children's Social Care should be in line with the LSCB Referrals Procedure.

Strategy Discussions should include any other agency that may hold information about the family, as far as is practicable given the time of the referral.

8. HUMBERSIDE POLICE

Where information relating to a suspected or actual injury to a non-mobile baby is received by Humberside Police from another source; PVP officers will themselves refer the matter to Multi-Agency Safeguarding Hub and participate in a Strategy Discussion.

On the basis of this Strategy Discussion, a plan for the investigation and assessment of the suspected injury will be developed jointly, in line with North East Lincolnshire LSCB Referrals Procedure.

9. PAEDIATRIC ASSESSMENT

The on call paediatric consultant will participate in all Strategy Discussions that are initiated in line with this Protocol.

Where an injury is identified by paediatric/ NLaG staff, they will follow the principles contained with this protocol, and where necessary refer the matter to the Children's Services Duty Team/Multi-agency Safeguarding Hub and participate in a Strategy Discussion.

All babies referred to Children's Social Care under this protocol must have a Child Protection medical assessment, undertaken by a Paediatrician.

Parents/carers must not be asked to take the baby to the hospital Emergency Department or to their GP as a substitute for assessment by a hospital Paediatrician.

Wherever possible, the examination should be attended by a member of Children's Social Care staff who is familiar with the family. However, in cases where this is not possible e.g. with a family who are not previously known to Children's Social Care, the worker(s) attending with the family should be familiar with the referral that has been made, the nature of the suspected injury etc.

See the relevant procedures in **Appendix B: Medical Assessments**.

The Paediatrician should arrange for additional medical investigations if the circumstances warrant this. The paediatrician will provide a verbal opinion at the time of the medical assessment, which will be followed up in writing. If the Social Worker, upon receipt of the report, is unclear about the medical opinion, they must contact the Paediatrician to clarify this.

In some cases e.g. where the injury was identified within a hospital setting, the baby may have already been seen by a paediatrician prior to referral. Where this is the case Children's Social Care should hold a Strategy Discussion with the Paediatrician and the Police, in order for the medical findings to be considered.

10. DECISION MAKING

The key principle of this protocol is that when a non-mobile baby has sustained injuries as outlined in this document, decisions should not be made by a single practitioner.

As a minimum, decisions should be made by two practitioner/ professionals (one of which should be a qualified health professional).

It should however be noted that this protocol does not seek to remove or undermine professional judgement, but instead support practitioners in making important decisions when safeguarding young people.

At the close of the S47 Enquiry, Children's Social Care should have made an assessment in relation to whether the baby has suffered, or is at risk of suffering, significant harm. This assessment should have been developed in full consultation with all relevant partner agencies.

In some cases, the outcomes of the S47 Enquiry may not be clear e.g. the findings of the paediatric assessment may be inconclusive or agencies may hold differing views about the level of risk. In such cases a Strategy Meeting should be convened by and chaired by a Team Manager or Principal Social Worker from the Children's Social Care in line with Procedures. The process of bringing the relevant professionals together to discuss the case may contribute to better assessment and outcomes.

This assessment will inform the action to be taken by Children's Social Care and/or Humberside Police.

Where there is professional disagreement the case should be referred to relevant managers or equivalent for resolution in line with Safeguarding Children Procedures.

Children's Social Care should also ensure that the outcomes of the S47 Enquiry are shared with the family (unless to do so would place the baby at increased risk) and all relevant partners.

In all agencies, the outcomes of the S47 Enquiry should be recorded in detail. This is particularly important where a decision is taken that no further action is required to protect the baby.

11. TIMESCALES

It is expected that all referrals under this protocol will be responded to, and assessment commenced on the same day that the referral is received. If this is not possible, then arrangements should be made for assessment to commence at the start of the following day at the latest.

In all cases, a Strategy Discussion and Paediatric Assessment should have been undertaken with 24 hours of receipt of the referral.

NEL LSCB would like to thank Wakefield and District Safeguarding Children Board.

12. APPENDICES

Click here to view Appendix A: Body Maps

Click here to view Appendix B: Medical Assessments.

Click here to view Appendix C: Common sites of accidental and non-accidental bruising