Kingston and Richmond
Safeguarding Children Partnership

BRUISING IN NON-MOBILE BABIES

A PROTOCOL FOR ASSESSMENT, MANAGEMENT AND REFERRAL BY PROFESSIONALS

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Target audience:	Multi-Agency Partners
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Table of Contents

1. Introduction

1.1 Following the national Child Safeguarding Practice Review Panel (CSPRP) briefing published in September 2022[1], KRSCP has reviewed and updated the current protocol on bruising in non-mobile infants to check for consistency with the evidence base and national guidelines.

1.2 The CSPRP briefing 2022 stated: In the rapid reviews and local child safeguarding practice reviews (LCSPRs) submitted to the Panel, there are often cases where young infants have previously presented with apparently minor injuries – with visible minor bruising – and a failure to follow established guidance, or inconsistencies within such guidance, have been highlighted as potential contributory factors to a subsequent serious incident or, ultimately, the child's death.

1.3 **Any bruising in a non-mobile infant must be assessed by a senior paediatrician combined with a multi-agency response**. See section 6 for pathway to be followed.

2. Aim of protocol

2.1 The aim of this agreed multi-agency protocol is to protect babies from harm caused by abuse; to identify medical causes of bruising; to reduce the risk of harm to baby and families from child protection investigations when abuse is not present.

The protocol aims to provide all frontline staff and managers, including those in children's social care, health, early years settings and the police with a clear pathway for the assessment, management and referral of non-mobile babies who present with any form of bruising.

Parents of babies going through assessments on this pathway should not feel stigmatised or shamed but be well informed of the reasons for the assessments due to the vulnerability of non-mobile babies.

2.2 This policy applies to all infants who are not independently mobile. **This policy does not include older children with disabilities who are non-mobile.**

3. Definitions

3.1 **A non-independently mobile or pre-mobile infant** is a baby who is not yet able to do any one of the following: crawling, bottom shuffling, pulling to stand, cruising or walking independently. NB: A baby who is beginning to roll is starting to be mobile and still covered by this protocol, please see section 4.5.

3.2 **A Bruise** is an injury where the skin has not been broken. A bruise forms when blood vessels under the skin break. Colouring and shades of the bruise may vary from yellow through green to brown or purple.

[1] https://www.gov.uk/government/publications/the-management-of-bruising-in-non-mobile-infants-paper

4. Evidence base

4.1 The NSPCC Statistics briefing: child deaths due to abuse or neglect – December 2021[2] notes:

- On average, at least one child is killed a week in the UK.
- Children under the age of one are the most likely age group to be killed by another person, followed by 16- to 24-year-olds.
- Child homicides are most commonly caused by the child's parent or step-parent.

4.2 Bruising in any child 'not independently mobile' should prompt suspicion of maltreatment. NICE guidance When to Suspect Child Maltreatment[3] (2017)

4.3 The Royal College Paediatrics and Child Health notes:

'Bruising was the most common injury in children who have been abused. It is also a common injury in non-abused children, the exception to this being pre-mobile infants where accidental bruising is rare (0-1.3%). The number of bruises a child sustains through normal activity increases as they get older and their level of independent mobility increases.' RCPCH Bruising: systematic review[4]

4.4 A review of the evidence base for bruising in babies found that non-mobile babies can have bruises that are non-abusive and explained (Bilson et al 2016). A response from RCPCH about the research evidence is awaited. The CSPRP briefing stated 'while the limitations of the research are acknowledged, the current evidence base is robust enough to support the conclusion that accidental bruising is uncommon in a baby who is not independently mobile, particularly in those who are younger, unable to roll and unable to crawl'.

4.5 Accidental bruising is rare in children unable to roll (1.3%), occurrence of non-abusive bruising in babies that can crawl is 10.9% (Kemp 2015).

5. Documentation of birth marks

All health professionals must take responsibility for documenting any known birth marks or birth injuries in the child parent health record (red book). To reduce unnecessary referrals for birth marks which are common in many babies, when a baby starts at nursery the nursery will have discussion with the parents regarding birth marks/birth injuries. Once this is confirmed by viewing the red book the nursery will document in their records any pre-existing mark(s) that have a medical explanation. This to prevent unnecessary referral for suspected bruising**. NB: the number of infants who attend day care settings/child minder who are not independently mobile is reportedly very few in Kingston and Richmond.**

Diagnosis of birthmarks is outside the scope of this protocol. Diagnosis will be made by a health professional with the appropriate competencies.

[2] https://learning.nspcc.org.uk/media/1652/statistics-briefing-child-deaths-abuse-neglect.pdf

[3] https://www.nice.org.uk/Guidance/CG89

[4] https://childprotection.rcpch.ac.uk/child-protection-evidence/bruising-systematic-review/

6. Pathways

6.1 The CSPRP briefing recommends the following:

a) A review by a health professional who has the appropriate expertise to assess the nature and presentation of the bruise, any associated injuries, and to appraise the circumstances of the presentation including the developmental stage of the child, whether there is any evidence of a medical condition that could have caused or contributed to the bruising, or a plausible explanation for the bruising.
b) A multi-agency discussion to consider any other information on the child and family and any known risks, and to jointly decide whether any further assessment, investigation or action is needed to support the family or protect the child. This multi-agency discussion should always include the health professional who reviewed the child.
c) KRSCP have agreed the multi-agency discussion is NOT a strategy meeting under S47 of the Children Act 1989. A MASH process will be undertaken by SPA for all infants who do not have an allocated social worker, a social worker will then discuss with the paediatrician. If an infant has an allocated social worker there will be a professionals' meeting/discussion between social worker and the examining paediatrician to agree next steps.

6.2 The CSPRP does not support blanket policies that require section 47 enquiries or their interventions without an initial appraisal of the circumstances of the presentation.

6.3 There are two pathways, depending on the situation that would need to be followed:

A) Non-mobile infant where emergency treatment is required (Appendix 1)

If a professional is concerned a child is seriously ill or injured, including generally unwell, or possibly with a decreased level of consciousness, lethargy, irritability or any signs of trauma such as swelling or bruising they should be referred immediately to hospital. The unwell neonate 2018[5]

Where an infant is thought to be seriously ill or injured arrange immediate medical care in hospital (call 999). Where possible the baby should be accompanied by their parent or carer.

A referral to hospital in an emergency **must not** be delayed by a referral to Children's Social Care.

A referral to children's social care must be made by the professional first noticing the injury and possible bruising. See section 6 referral to social care.

The child will have a comprehensive medical assessment as appropriate. See section 7 Medical assessment of bruising.

[5] https://www.rcemlearning.co.uk/foamed/the-unwell-neonate-and-infant/

B) Non mobile infant when bruising is identified any health professional – emergency treatment not required. (Appendix 1)

The health professional who identifies the bruising must arrange for the child to be reviewed by a paediatrician at a local hospital (see appendix 1) For local hospital contact details who have adopted this protocol by calling the hospital switchboard and asking for the on-call paediatrician. Details of the suspected bruise must be given to the paediatrician including location and approximate size and shape. A body map must be completed (appendix 3) and sent securely via NHS email. They must document and inform the paediatrician what the parent/carers explanation is for the suspected bruising.

C) Non-mobile infant when bruising is identified by a non-health professional – emergency treatment not required

The professional who identifies the bruising must refer to the child's local Children's Social Services (according to child's address) Appendix 2 for Children's Social Care referral contact details. Details of the suspected bruise must be documented in the referral including what the parent/carers explanation is for the suspected bruise.

6.4 Body maps to record bruising should be completed in all cases where there are injuries of concern (see Appendix 3). For non-medical staff, this should only be for visible bruising. This is to address the potential for inaccurate recording when there are multiple bruises / patterns of bruising over time, as identified in both national and local child safeguarding practice reviews.

6.5 Referral to hospital must be made with parental consent, however, if consent is if refused and there is a suspected bruise, professionals need to take action to safeguard the child, e.g. referral to Children's Social Care without consent. Parents will be informed that the social worker will be updated by the paediatrician following their medical assessment.

6.6 It is the responsibility of the professional who identifies the bruise, to ensure the baby attends hospital as soon as possible and to confirm attendance. They need to use their professional judgement to assess the parent's responses and compliance to this request and take the necessary steps to ensure the child's safety. This may include calling the police if the professional suspects the parent/carer will not attend the hospital as requested. If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to the police and children's services notified of this course of action. If possible, the child should be kept under supervision until steps can be taken to secure his or her safety.

6.7 A referral to children's social care must be made by the professional first noticing the suspected bruising. See section 7 referral to social care.

6.8 A paediatrician may observe a bruise incidentally on a non-mobile baby during an examination for other reasons. If a bruise is noted a referral to children's social care should be made unless there is a clear medical explanation. (See section 8 medical exam and referral).

NB: a health professional e.g., GP/health visitor/midwife who has the appropriate competencies and experience to recognise pigmentation caused by a birth mark must document this diagnosis in the child's red book. The referral process to a paediatrician is not required unless a bruise is suspected.

7. Referral to Children's Social Care and Multi-Agency Response

7.1 All suspected bruises in non-mobile infants must be referred to Children's Social Care by the professional who first identifies the suspected bruise. (**The exception to this is when an infant is being examined by a paediatrician and a bruise is identified with a clear medical explanation – e.g. birth trauma, birth mark, infection or bleeding disorders**).

7.2 All referrals **must** include any explanation given by the parent/carer for the suspected bruising. Try to use the exact words given. Referrals must include the name of the paediatrician spoken to at the hospital.

7.3 Following paediatric assessment there will be a multi-agency discussion to consider any other information on the child and family and any known risks, and to jointly decide whether any further assessment, investigation (including strategy meeting) or action is needed to support the family or protect the child. This multi-agency discussion should always include the paediatrician and the referring professional who reviewed the child.

8. Information to be included in referrals to paediatrician & children's social care

- When did you notice this suspected bruise?
- Has anyone else seen the suspected bruise - professional or another adult?
- Does the parent / carer have any worries about who or what may have caused the suspected bruise?
- Who is in the family household (including other children, fathers, and significant others), who lives with the child, who are regular visitors?
- Where does the child spend time - e.g. Nursery, Childminder, Friend - and for how long?
- Observations of the presentation of the parent / carer within this discussion and any professional judgement linked to this.

9. Medical assessment of suspected bruising

9.1 Bruising in non-mobile babies may have a medical explanation; this includes injuries through birth trauma, birth marks and other medical reasons for example: infection, iatrogenic (e.g. blood tests) or clotting disorders.

9.2 All bruising in young babies is significant and should not be ignored. A bruise must never be interpreted in isolation, the paediatrician will assess the nature and presentation of the bruise, any associated injuries, and appraise the circumstances of the presentation including the developmental stage of the child, social history and whether there is any evidence of a medical condition that could have caused or contributed to the bruising, or a plausible explanation for the bruising. A comprehensive clinical examination, holistic assessment and relevant investigations must be undertaken. (RCPCH Child Protection Companion, Chapter 6).

10. Outcomes of paediatric assessment

10.1 Outcome 1: Not a bruise – there is another explanation identified e.g. birth mark, infection. The paediatrician will update parents/carers and children's social care; If there are no concerns based on previous history / risk factors, **no Further Multi Agency Assessment is required.** NB: if the referrer was a health professional the paediatrician will inform the referrer.

10.2 Outcome 2: Confirmed bruise with a medical explanation e.g. birth trauma, or a plausible accidental explanation. Paediatrician to update parents/carers and children's social care and request **discussion** with duty social worker (SPA) to consider any other information on the child and family and any known risks, and to jointly decide whether any further assessment, investigation or action is needed to support the family or protect the child. This discussion should always include the paediatrician who reviewed the child and the referring professional. NB: *NICE guidance allows paediatricians to decide whether bruise is suspicious or not.*

10.3 Outcome 3: confirmed bruise without medical or plausible explanation. Paediatrician to update Children's Social Care who will convene a **strategy meeting**. In this situation the baby will usually be admitted to hospital whilst investigations are undertaken.

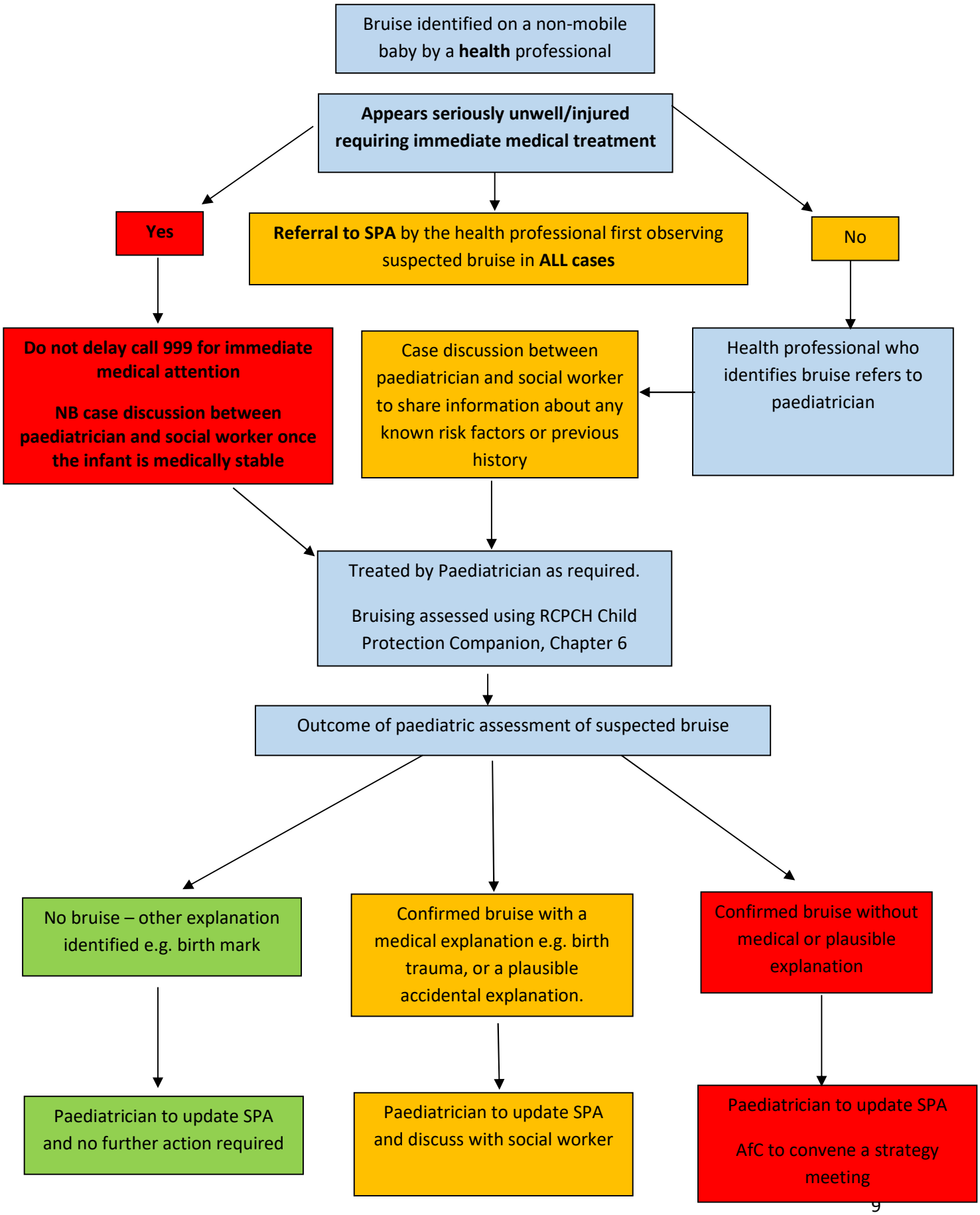
11. Impact of protocol

There will be no automatic Section 47 strategy meeting for suspected bruising in non-mobile babies prior to assessment by a paediatrician.

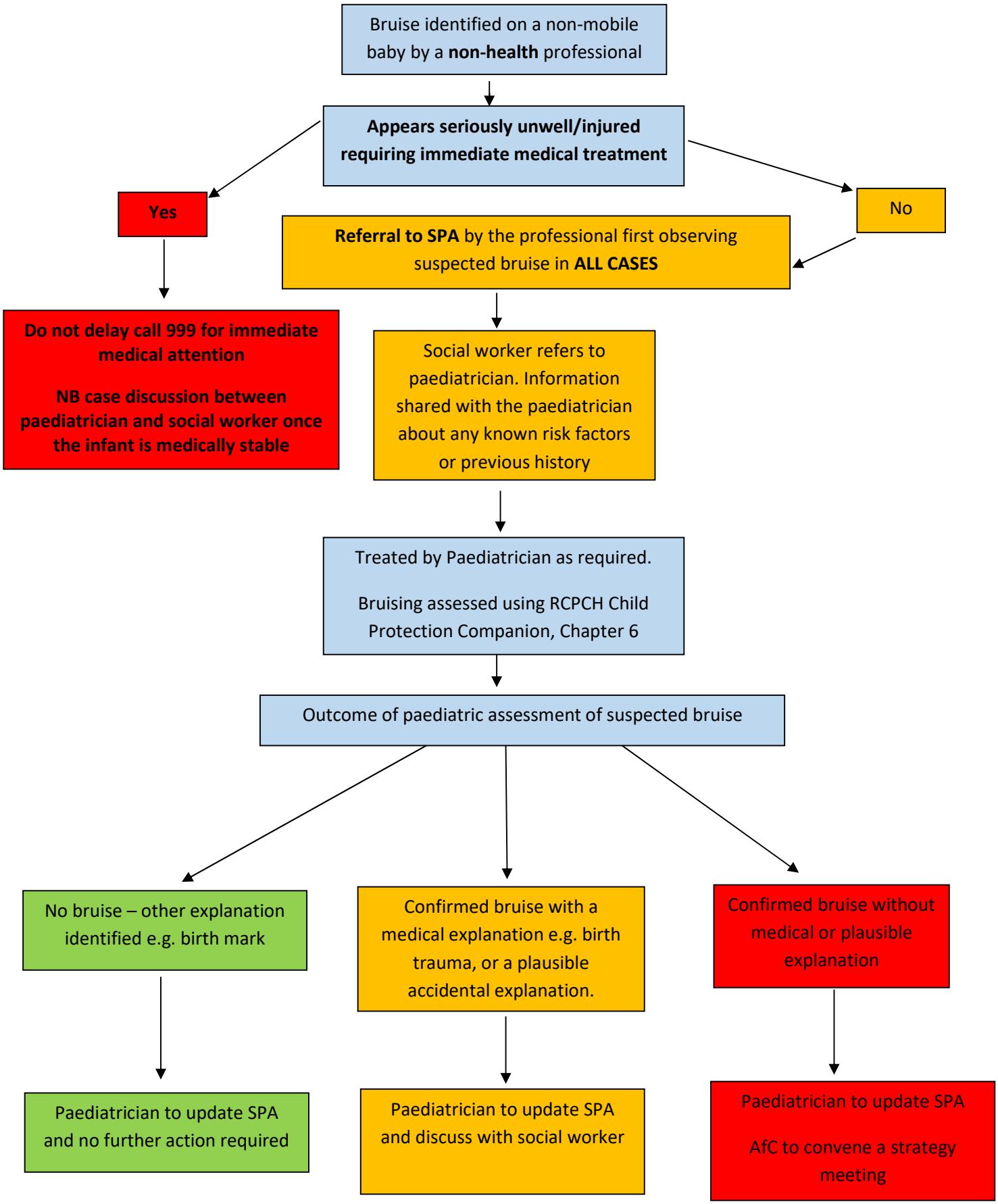
Paediatricians will see a reduction in referrals for child protection medicals for already diagnosed birth marks. Child protection medicals are reported in provider assurance reports.

The number of MASH processes will increase this will be monitored through the MASH Strategic Board Data report.

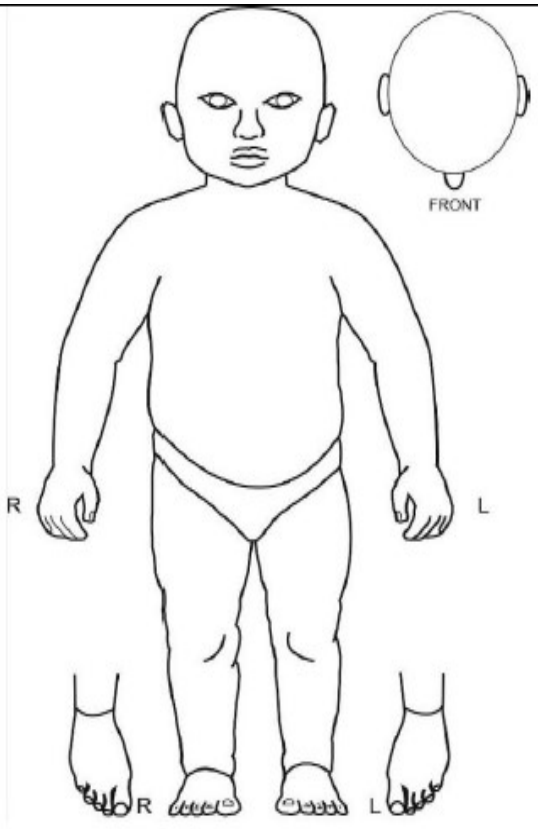
APPENDIX 1: Flowchart for Management of Suspected Bruising on a Non-Mobile Baby Identified by a Health Professional

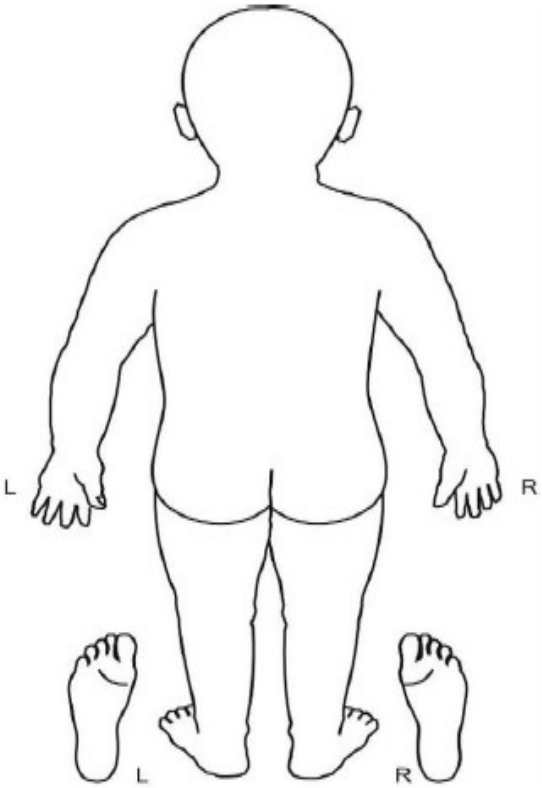


APPENDIX 2: Flowchart for Management of Suspected Bruising on a Non-Mobile Baby Identified by a Non-Health Professional



Appendix 3: Body Maps





Appendix 4: Contact Details

Kingston Hospital Foundation Trust

1. Contact Kingston Hospital switchboard: 020 8546 7711 Bleep 732

2. Call Dolphin (PAU) ward: 020 8546 7711 - extension 2328 and ask to speak to on call paediatrician

West Middlesex University Hospital

1. Mobile Hot-phone - held by consultant paediatrician (09.00-21.00 hours) 07901 008688
2. Via West Middlesex switchboard 020 8560 2121 and ask for paediatric consultant on call
3. Office hot-phone 020 8321 6495 -will be picked up only in office hours by the paediatric admin team who will then locate the paediatrician

Children's Social Care

Achieving for Children Single Point of Access: 020 8547 5008

Out of Hours: 020 8770 5000

https://kr.afcinfo.org.uk/pages/community-information/information-and-advice/safeguarding-and-child-protection/single-point-of-access-spa