Injuries to non-mobile babies and children

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This guidance outlines the initial response expected when non-mobile babies or children present with injuries that might have been caused through abuse or neglect. It highlights the particular vulnerabilities of non-mobile babies and children, the importance of identifying signs of abuse and neglect and the necessity to act quickly where abuse or neglect is suspected.

Lead Professional/Author	Dr S. Bohin, Paediatrician, Dr J. Porritt, GP
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Contact Details	ISCP Business Manager: David.Foote@gov.gg

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1. Introduction

1.1. Bruising is the most common form of injury seen in children who have been physically abused. It is also strongly related to mobility; once children are independently mobile they get bruised through everyday activity and accidents. At the same time it is very unusual to see bruising in a baby who is not independently mobile.

1.2. It is important to assess any injury to a baby or child in the context of medical and social history, their developmental stage and the explanation given. The National Institute for Health and Care Excellence (NICE) has issued guidance explaining that child maltreatment should be suspected in any case of injury to a non-mobile baby. Babies are extremely unlikely to injure themselves, with the possible exception of superficial scratches, particularly to the face.

1.3. It is also important to consider injuries to older children who are not independently mobile through disability or illness.

1.4. There are some situations where injuries in non-mobile babies or children have an innocent explanation. However, before excluding child maltreatment as an explanation for the injury, it is important to consult a more experienced colleague or a named or designated professional for safeguarding children.

1.5. Decisions that injuries to non-mobile babies or children are not associated with child maltreatment must be made jointly and accurately recorded on the child's record.

1.6. Definitions of terms used and abbreviations

Child – a child is a person under 18 years old.

Children with disabilities – immobility in older children through disability or illness should also be taken into account under this procedure. Children with disabilities are more vulnerable to abuse whether they are mobile or not. Also consider the ISCP *Protecting Children with Disabilities from Abuse* guidance.

ISCP – Islands Safeguarding Children Partnership.

MASH – the Multi-Agency Support Hub is the single point of entry for multi-agency help and support for children and families.

NICE – the National Institute for Health and Care Excellence is a UK Non Departmental Public Body providing national guidance and quality standards for improving health and social care.

Non-mobile baby – a baby who is not yet moving independently. For the purpose of this procedure, babies who can roll are considered to be non-mobile.

2. Objectives

2.1. This document covers the procedures to be followed when there are concerns about injuries to non-mobile babies or children. It outlines:

- Types of injuries that might be observed
- Actions to be taken by those observing the injury
- Enquiries to the Multi-Agency Support Hub (MASH)
- Actions following an enquiry
- Expected timescales

2.2. This document cannot provide a detailed list of all possible injuries and explanations for them but highlights some injuries that should alert practitioners to the possibility of abuse. There is further information and advice available in the source documents listed in the references section.

3. Injuries to non-mobile babies and children

3.1. Injuries to children should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history. Any explanation given should be considered alongside the child's:

- presentation
- normal activities
- existing medical conditions
- age and developmental stage

3.2. Consideration should also be given to the plausibility of explanations and consistency between the child's own account of the situation (if possible) and that given by parents or carers, as well as consistency of accounts between parents and accounts over time.

3.3. Any child who has unexplained signs of pain or illness should be seen promptly by a doctor.

4. Types of injury

Bruising

4.1. Bruising is the most common form of injury seen in children who have been physically abused. The head is the most common site of bruising in child abuse, along with the ear and the neck. Babies are particularly vulnerable to physical abuse.

4.2. There are some medical explanations for bruising including birth trauma, some medical conditions causing marks to the skin or birth marks that can look like bruising. If these

exist as explanations they should be accurately recorded on the child's medical records.

Cuts, abrasions or scars

4.3. Cuts, abrasions or scars should alert a practitioner to the possibility of abuse, especially when they are on a child who is not independently mobile. Other alerting features include when they are multiple, symmetrically distributed, on an area of the body that is usually protected by clothing, on the eyes, ears or sides of face or when they look like ligature marks.

Eye injuries

4.4. Subconjunctival haemorrhages refer to bleeding within the whites of the eye and are similar to bruising. A baby that develops a subconjunctival haemorrhage which is not birth related, or where there is no other apparent cause, should be examined by a paediatrician. Retinal haemorrhages (bleeding at the back of the eye) are suspicious in the absence of major confirmed accidental injuries, a medical condition or birth-related causes. Rarely, a non-mobile baby could cause a superficial scratch to their own eye.

Fractures

4.5. Fractures occur in a significant proportion of abused children – 80 percent of them in children under 18 months. Many abusive fractures are not obvious unless x-rays are taken, especially in children under two years. Physically abused children frequently have multiple fractures that show different stages of healing. Rib fractures in children who have not been involved in a major accident are highly indicative of abuse as are fractured femurs in children who are not yet walking. A spiral fracture is the most common fracture of the femur in abused children under 15 months.

Head and spinal injuries

4.6. Abusive head trauma (AHT), involving injury to the brain or bleeding within the structures around the brain, is the most serious form of physical abuse with the most severe consequences for the child's future wellbeing. It is the most common cause of death among children who have been abused. AHT can arise from shaking, shaking and impact or impact injuries. Many children who suffer AHT have suffered previous physical abuse, which is why it is vital that any suspicion of physical abuse to a baby is fully investigated to prevent further abuse of greater severity.

4.7. Sometimes the child will have obvious signs of brain injury but they might sometimes present with less obvious signs such as increased head circumference, poor feeding or excessive crying. AHT is often present with other injuries, especially spinal neck injuries, retinal haemorrhages or rib fractures. It is also important to look for signs of any other injuries.

Oral injuries and bites

4.8. Injuries to the mouth are common in physical abuse, the most common abusive injury being to the lips. A torn labial frenum used to be seen as diagnostic of physical abuse, but when present in abused children they are frequently seen with multiple injuries. Injuries to the mouth can occur accidentally from falls or in play so would be suspicious in non-mobile babies or children. In the absence of a suitable explanation, assessments for children under two years should include a full skeletal survey.

4.9. Any human bite mark could indicate abuse and should be fully assessed. Equally an animal bite mark on a non-mobile baby or child could be an indication of neglect.

Signs of sexual abuse

4.10. Any injury to the ano-genital area – bruising, cuts, abrasions, swelling – or the presence of discomfort, infection, discharge, or foreign bodies can be a sign of sexual abuse.

Thermal injuries

4.11. Burns and scalds indicate a strong possibility of physical abuse or neglect in children who are not independently mobile. Accidental burns are more likely to happen once children become mobile – e.g. toddlers reaching out to grab hot objects, typically causing a single burn to the palm of the hand. Intentional burns are often multiple, clearly demarcated and involve areas of the body other than the hands. Accidental scalds usually occur as spill injuries whereas intentional scalds are often bilateral and symmetrical, with sharply demarcated borders. Siblings may be blamed for causing scalds, which, if true, could also be an indication of neglect.

5. Actions to be taken

5.1. Whenever a practitioner identifies an injury to a non-mobile baby (or child) they should immediately seek an explanation for the injury from the parent or carer, and the child (if possible).

5.2. Any injury to a child under two years old, or for any child where there might be child protection concerns, should be examined by a paediatrician. Early referral is important as such physical injuries need to be assessed within 24 hours.

5.3. The identifying practitioner must then discuss the injury and explanation with their line manager or safeguarding lead. A record of both the injury and explanation and the discussion should be made.

5.4. A *joint* decision should then be made about the suitability of the explanation for the injury and whether to make enquiries to the Multi-Agency Support Hub (MASH) for the child. Safeguarding advice can be sought from a social worker in the MASH or duty social worker (out-of-hours) in relation to making such enquiries.

5.5. If the child is believed to be at immediate risk of harm, or if a crime is believed to have been committed, the police should be notified immediately of the concerns by telephone: **999**.

5.6. If the baby (or child) appears ill or seriously injured, emergency medical treatment should be sought and the MASH or duty social worker (out-of-hours) notified of the concerns.

5.7. In all cases details of the concerns, identified injuries, explanations given, decisions made and actions taken should be accurately recorded in the child's records.

5.8. If the decision is to make an enquiry to MASH the usual process for making an enquiry should be followed and the MASH will then take responsibility for any ongoing investigation. The enquiry to MASH is the responsibility of the first practitioner to identify, or be made aware of, the injury.

6. Making an enquiry to the Multi-Agency Support Hub (MASH)

6.1. Whenever a joint decision has been reached that an identified injury to a non-mobile baby (or child) might have arisen as a result of abuse or neglect then an enquiry must be made to the MASH following the ISCP procedures.

6.2. In most circumstances the identifying practitioner will inform the parents or carers that an enquiry to MASH is being made in relation to the practitioners concerns about the injury. The only exception to this would be if informing the parents might put the baby or others at further risk of harm. Advice can be sought from the MASH in relation to informing the parents of the enquiry. In all cases the MASH need to know if the parents are aware of the enquiry.

6.3. It is the responsibility of the MASH to refer the case for the appropriate assessments and investigation.

6.4. For cases where the child is suspected to have been harmed through abuse or neglect the MASH should be contacted by phone without delay on: **01481 723182** or the emergency duty team should be contacted out of office hours on: **01481 725241**.

6.5. If there are concerns for the child's immediate safety the police should be called on: **999**.

7. Actions following an enquiry

7.1. Enquiries made to MASH or the Emergency Duty Team under this procedure will always be considered a high priority due to the vulnerability of the children concerned.

7.2. Actions to be taken following the enquiry will follow the ISCP procedures, gathering initial information and deciding on how to proceed with an investigation, most likely through convening a Strategy Discussion.

7.3. Strategy Discussions should include any other agency that might hold information about the family, as far as is practicable, depending on the time of the enquiry.

7.4. Where information about a suspected or actual injury to a non-mobile baby is received by the police from another source, the police will take the matter to the MASH or duty social worker and participate in a Strategy Discussion.

7.5. The on-call paediatrician should also participate in any Strategy Discussion that is initiated by this procedure. Medical assessments should be conducted in line with the ISCP Medical Assessment procedures.

7.6. Parents or carers must not be asked to take the baby to the hospital emergency department or their GP as an alternative for assessment by the paediatrician.

7.7. In any case where, after investigation, it is judged that there might be a need for compulsory intervention to ensure the care and protection of the child, a referral must be made to the Children's Convenor **01481 213290**.

8. Timescales

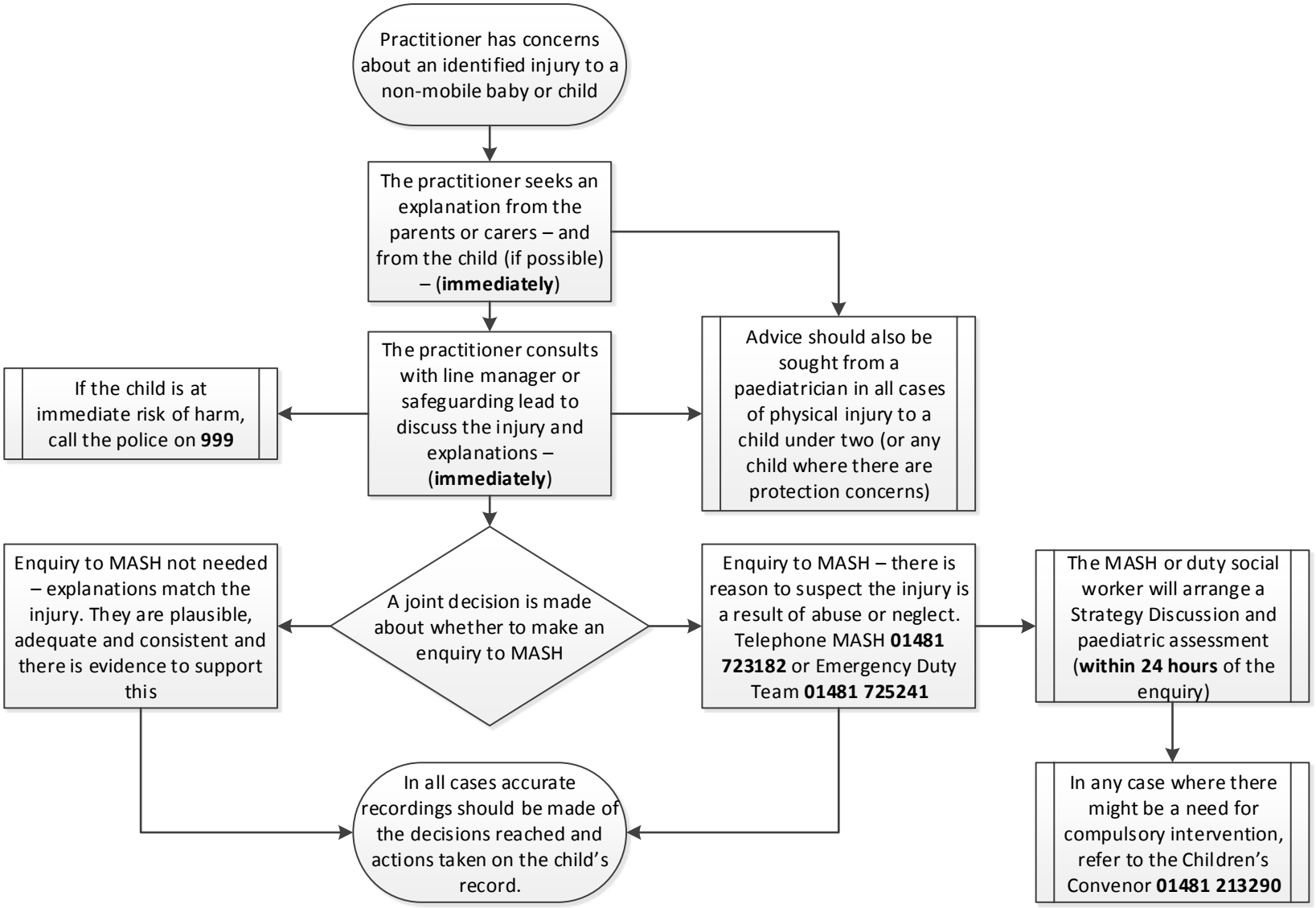
8.1. When an enquiry is made to MASH concerning any injury to a non-mobile baby (or child) that might have arisen as a result of abuse or neglect, it will be responded to and an assessment commenced on the day of the enquiry. When this is not possible, arrangements should be made to start the assessment at the start of the following day.

8.2. In all cases a Strategy Discussion and paediatric assessment should take place within 24 hours of the enquiry.

8.3. In cases where a baby or child is considered to be at immediate risk of harm the Police should be contacted immediately on 999.

Actions to be taken upon identifying an injury in a non-mobile child

(NB – for the purposes of this policy 'non-mobile' includes babies who can roll)



9. Review

9.1. This procedure will be kept under review by the lead professional and the ISCP Learning and Improvement sub-committee.

9.2. The procedure will be reviewed in full in three years from the date of publication.

10. Distribution

10.1. The guidance will be published on the ISCP website and circulated to members of the ISCP and ISCP sub-committees.

10.2. Members will circulate the guidance within their own organisation.

10.3. The ISCP will publicise the guidance alongside other relevant procedures.

11. References

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