Multi-Agency Guidance for Injuries in NON-MOBILE Babies 2023

South Glos and Bristol multi agency working group.
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Following the death of a baby in South Gloucestershire a Serious Case review was undertaken which identified that the baby had been presented to professionals on a number of occasions prior to their death with what appeared to be potentially plausible, accidental minor injuries. Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission.

Non-mobile babies cannot cause injuries to themselves and therefore must be considered at significant risk of abuse. Multi-agency information sharing allows for sensible, informed judgements regarding the child's safety to be made.

1. AIM OF GUIDANCE

The aim of this Guidance is to ensure that professionals

1. are aware that even minor injuries could be a pointer to serious abuse in non-mobile babies
2. know that such injuries, however plausible, must routinely lead to multi-agency information sharing
3. support professionals to identify potential concerns and make referrals as appropriate

This guidance is to guide the management of well babies presenting with an isolated bruise.
If practitioners are concerned about the baby's immediate health they should follow usual procedures in seeking urgent medical assistance.

If you are an Early Years Practitioner please see addendum for specific advice and flow chart.

2. TERMINOLOGY

Baby: This Guidance uses the term 'baby' rather than 'infant' (an infant is defined as a baby less than 12 months of age) to recognise that some babies over 12 months will not be independently mobile e.g. disabled babies.

Injury: injuries such as bruises, fractures, burns/scalds, eye injuries eg corneal abrasions, bleeding from the nose or mouth, bumps to the head. Scratches may be self-inflicted by babies and professionals can use their judgement or discuss with a senior as to whether the child needs social care checks completed / examination by a paediatrician or not.

Mobile: a baby who can crawl, pull to stand, 'cruise' around furniture, or is toddling

Non-mobile: babies who cannot do any of the above. Babies who can roll are classed as non-mobile for the purposes of this document. Professionals must use their judgement regarding babies who can sit independently but cannot crawl, depending on severity of the injury and its plausibility.

MIU : Minor Injuries Unit

Congenital dermal melanocytosis – previously known as (Mongolian) blue spot – this terminology is outdated and has been replaced by congenital dermal melanocytosis

3. USING PROFESSIONAL JUDGEMENT:

This document is written on the understanding that professionals are allowed to use their professional judgement and common sense. Professional judgement is based on your experience, training and role. However, it is important to remember that non-accidental injuries often occur in

the same body areas as accidental ones, and professionals can be seduced by plausible explanations**.**

Even senior, experienced professionals should discuss cases with peers or senior colleagues if they feel an injury has a plausible explanation. Such colleagues could be your line manager, your safeguarding lead, or a consultant community paediatrician. Social care and police checks should still be undertaken even if the cause of the injury is accidental to inform the decision making. Professionals not working in Health should ALWAYS discuss an injury in a non-mobile baby with a Healthcare professional as soon as possible.

4. BENIGN SKIN MARKS

This Guidance refers only to injuries. Where it is believed a skin mark could be a birth mark or similar benign medical skin condition, professionals should be encouraged to use their judgement. Congenital dermal melanocytosis (previously known as blue spots). Birth marks are not always present at birth and can develop up to 3 months of age *(please see attached re Characteristics of congenital dermal melanocytosis / blue spot birth marks)*.

Midwives/ Health Visitors/ GPs should check for and record any birthmarks, or injuries that have occurred as a result of the birth itself, including recording in Parent Held Record (Red Book), ideally on body map, so other professionals can see this (with parental permission). If any doubt exists about the nature of a skin mark, the baby's parents / carers should be requested to seek a medical opinion from their GP.

Encouraging parents to take photographs of skin marks can be very helpful in determining how long it has been present and also how it has evolved – NB birth marks do not come and go, and are not always visible at birth, can appear up to three months after birth.

Parental photographs (often held on their phones) can be a valuable source of information regarding how long a mark has been on the skin. Whilst a photograph cannot replace inspection / examination by a health professional, they can assist in helping health professionals triage the child, and potentially discuss the case with colleagues.

If there is doubt regarding what type of mark it is then photographs may be requested – these should only be taken using work phones / cameras if available and should subsequently be stored in the trusts imaging management system by any professional whoeither takes or receives these.

Social care and police checks **should not** be undertaken if it is felt that the mark is a birth mark.

If there is uncertainty regarding whether the mark is a birthmark or a bruise then it may be appropriate to seek review more locally, with the family's primary care team. The baby should be seen by a GP or nurse practitioner (or similarly qualified professional) who has expertise and confidence in seeing babies.

GPs (and colleagues) may be asked to review these babies locally to avoid families having to travel long distances; this examination is done with the full expectation that if the GP / examining professional has any concerns that it may be a bruise the Community Paediatrician will be happy to discuss and to see the same day.

5. HISTORY OF TRAUMA WITHOUT VISIBLE INJURY

If a baby is presented following a history of trauma they should be checked for injuries by the health professional that they have told.

If no injury is observed and the professional is satisfied with the account of how the accident happened then they do not need to make a referral for social care checks or examination under this policy.
If the history of events or presentation raises any safeguarding concerns (for example an account of shaking), they need to follow normal safeguarding procedures and complete appropriate referrals.

6. NON-MOBILE BABIES PRESENTING WITH AN INJURY

In **ALL CASES** of observed injury an explanation should be sought, and the explanation(s) recorded. Health Professionals should fully undress a baby to check for further injuries. Arrangements must be made for non-mobile babies to be fully examined. It is imperative that the professional does **not** suggest to the parent/carer how the injury occurred.

Any explanation for the injury should be critically considered within the context of:

- **The nature and site of the injury**
- **The baby's developmental abilities**
- **The family and social circumstances including current safety of sibs/other children**

  It is fundamental that the assessment of the family & social circumstances, including the analysis and decision making, is documented. Particular attention should be paid to whether the reported **mechanism is inconsistent with the injury.**

All those living within the family home and partners who do not live there but participate in the child's care, must be considered as part of the assessment.

Due to the significant risk of abusive injury in a non-mobile baby **ALL non-mobile babies with an injury** should be discussed with a Hospital or Community Paediatrician, or Emergency Department (ED) with trained paediatric staff, even if there is a plausible explanation.

Any non-mobile baby with an injury requiring medical treatment should be seen without delay at the Children's Hospital Emergency Department, including those with bleeding from the nose, mouth and/or ear.

If the mark is an isolated injury in an otherwise well baby the professional can contact the on-call Consultant Community Paediatrician the same day (via BRI switchboard 0117 9230000) to discuss the case rather than send the child immediately to the ED.

If there is any uncertainty about the severity of the injury and where to refer it should be discussed with the on-call community paediatrician.

If an examination is required it will be arranged for the same day/within 24 hours. Consultant Paediatricians (ED, Hospital, or Community) have the right to use their judgement when considering injuries in non-mobile babies, and in certain situations may deem it unnecessary for a baby to be brought to hospital to be examined by a paediatrician.

Social care and police checks should be undertaken in all cases. These should be done by the referring professional, and families should be advised this is a standard part of the process.- (see 7)

Where a non-mobile baby with an injury presents at an ED or Minor Injuries Unit (MIU) he/she must be seen by a doctor of at least registrar status or by a paediatric trained nurse practitioner. If such staff are not working at the ED/MIU, the child must be referred to the Bristol Royal Hospital for Children or similar facility. After full examination and multi-agency checks, the baby should be discussed with, or preferably reviewed by a Consultant Paediatrician (Hospital/Community) or ED Consultant with Paediatric training.

Where the professional has identified that a referral should be made to the Emergency Department or Community Paediatrician, the baby's parent / carer should be informed that a person with parental responsibility will be required to attend with their baby or at the very least give consent for a medical examination to take place. The professional should provide the ED or Paediatrician the name and date of birth of the baby, and contact details of parent/carer so they can be contacted if they do not arrive. The professional should discuss with the parent/carer how they will get to hospital (supporting them to arrange transport – and considering a taxi as last resort, claim back through expenses, if this is the only way)) and should ALWAYS contact the hospital the next working day to confirm that the baby has attended.

It is only necessary for one person with parental responsibility to give consent for examination. In a situation where all persons with parental responsibility **refuse consent** for a non-mobile baby with an injury to be medically examined, the professional should discuss the matter with the Consultant Community Paediatrician on call (via BRI switchboard 0117 9230000) to establish whether a medical examination is definitely required. **If an examination is deemed necessary, Social Care's immediate involvement is essential and a referral should be made by the attending professional.**

7. MAKING A REFERAL TO SOCIAL CARE

The Parent / Carer should be informed that all non-mobile babies with any injury require standard record checks with social care and police to establish whether any person or situation posing a known risk to children is present in the household.

The professional must contact First Response (Bristol) / Access and Response team (South Glos) Children's Front Door (N Somerset)/ Emergency Duty team (out of hours) to request a check of relevant carers by social care. The professional should be able to share details including DOB of all residents of the household over the age of 10 years old, and the names and DOBs of any relevant adults who were present or whose care the baby was in at the time of the incident (e.g. parent's partner, grandparents, family members).

Professionals should make clear to social care whether they are making a safeguarding referral or are requesting checks under this policy.

In almost all cases being seen under this policy the initial request will be for checks under the non mobile baby policy only.

The checks are initiated by social care (at health's request) and they also check with the police to ensure that no adults in the house are known to either of the services. Although the checks are done they are labelled as non-mobile baby checks so that this is not detrimental to the parents in the future (though if a lot of checks were being done for the same child this may flag up a concern in its' own right.)

Make social care aware of the events, the explanation given, any action required, where the child has been sent for examination and who from health is taking the lead on the situation so that relevant information can be shared and discussed after checks. The safety and whereabouts of other children in the family must be considered.

Parents should be provided with the information leaflet for parents about this process. This is appended at the bottom of this policy and can be handed or emailed to the family.

The professionals may negotiate with hospital staff that they contact Social Care once the baby is seen if more appropriate. In most cases however, the referring professional will be best informed and should make the call to Children's Services.

Social Care should inform the paediatrician / health lead of the outcome of the checks.

9. THE MEDICAL EXAMINATION

The Paediatrician should take into account the developmental capabilities of the baby and all information provided when the cause of the injury is being assessed.

Accidental Cause

- If the cause of the injury is felt to be accidental, the Paediatrician should still ensure that families of non-mobile babies are checked via Social Care who will liaise with police.
- If information from the checks increases concerns that the baby has been abused / neglected, or is at risk of significant harm, a referral to Social Care should be made in accordance with the South West Child Protection Procedures.
- If after multi-agency checks it is judged that the injury is accidental but the baby already has an allocated Social Worker (SW), the Paediatrician must ensure that the SW is informed in writing of the outcome of the medical examination.
- The Paediatrician must inform the referring professional and Primary Care (and other professionals as appropriate) of the outcome of the medical examination and of any support/safeguarding intervention being taken. This can be done via discharge summary or medical report.

Possible Non-Accidental / Inflicted Cause

If medical examination raises concern of possible non-accidental or inflicted injury to the infant then this must be pursued as an urgent safeguarding referral under usual child protection procedures with full medical examination and medical investigations, and a full medical report should be provided.

Disagreement between professionals regarding the safety of a child must be resolved using the relevant Safeguarding Board's Resolution of Professional Differences/ Escalation Policy (held on Local safeguarding partnership websites).

RELATED POLICIES, PROCEDURES AND GUIDANCE

- SW Child Protection Procedures http://www.online-procedures.co.uk/swcpp/
- Working Together 2018 Signs and symptoms of possible child abuse Bruising
- NSPCC information leaflet http://www.nspcc.org.uk/search/?query=core%20info
- Cardiff Child Protection Systematic Reviews http://www.core-info.cardiff.ac.uk/

Useful contacts

Community paediatrician – via UHBW switchboard – 0117 923 0000 and ask to contact the community paediatrician – 24 hour availability

UHBW Children's ED – 0117 342 8666

First Response – Bristol social care referrals – 0117 903 6444

Access and Response Team South Glos – 01454 866 000

Front Door – North Somerset 01275 888 808

Local Safeguarding Partnership escalation policies

Bristol - (bristolsafeguarding.org/ policies-and-guidance)

South Gloucestershire - Resolution-of-Profesisonal-Differences-Policy-Oct-2020-FINAL.pdf (southglos.gov.uk)

North Somerset - Escalation Policy | North Somerset Online Directory (n-somerset.gov.uk)

RESEARCH:

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4. McIntosh N, Mok JY, Margerison A Epidemiology of oronasal hemorrhage in the first 2 years of life: implications for child protection. *Pediatrics* 2007; **120**(5):1074-8

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7. T. Sieswerda – Hoogendocrn et al. European Journal of Pediatrics 2012. Abuse Head Trauma. **171**:415-423

8. Maguire S, et al. Archives of Disease in Childhood 2009. Which clinical features distinguish inflicted from non-inflicted brain injury? A systematic Review: **94**: 860-867

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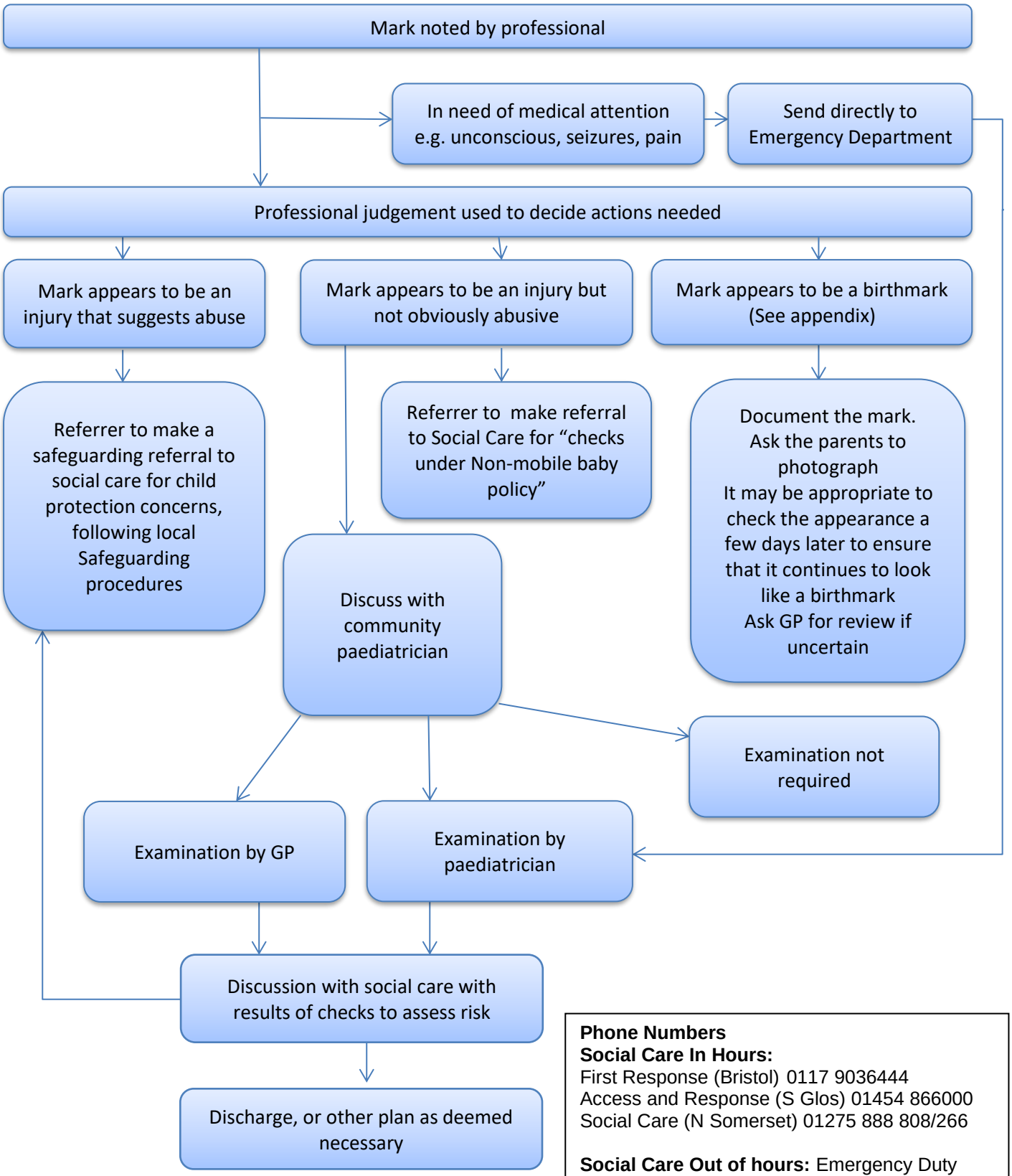
Thanks and acknowledgement to Dr Andrea Warlow and Western Bay PPP subgroup, Neath and Port Talbot Safeguarding Board, for permission to adapt their Minor Injuries in Babies Policy.

Flow chart for marks in non-mobile babies



Phone Numbers
Social Care In Hours:
First Response (Bristol) 0117 9036444
Access and Response (S Glos) 01454 866000
Social Care (N Somerset) 01275 888 808/266

Social Care Out of hours: Emergency Duty Team 01454 615165

Refer to Community paediatrician
0117 923 0000 and ask for the community paediatrician on call

Best Evidence Safeguarding Tool

University Hospitals Bristol NHS
NHS Foundation Trust

Do my parents / carers have any risky behaviours which may impact on how they look after me? Does a social worker know me?

NO DON'T KNOW YES

Do my parents / carers comfort and cuddle me? Do I respond to them?

NO DON'T KNOW YES

Was I being cared for safely when my accident happened?

NO DON'T KNOW YES

ADDRESSOGRAPH LABEL

Name: .....

Date of Birth: .....

Hospital No: .....

Ward / Hospital: .....

Have you fully undressed and examined me? Am I clean and well cared for?

NO DON'T KNOW YES

Have you witnessed / confirmed I am developmentally capable of doing what my parents / carers describe?

NO DON'T KNOW YES

Was I born prematurely, kept in hospital after birth or a low birth weight?

NO DON'T KNOW YES

If I have a fracture, burn or scald have you excluded these specific injury risks?

NO DON'T KNOW YES

Do I have any unexplained marks, bruises, petechiae, even if very small?

NO DON'T KNOW YES

Is the history of how I hurt myself clear, consistent and plausible?

NO DON'T KNOW YES

Did my parents / carers bring me promptly for treatment and give me first aid?

NO DON'T KNOW YES

Name.....

Signature.....

Date.....

Guidance Notes

Please answer all 10 questions by ticking the corresponding box.
If your infant patient has any red flags are they safe to be discharged without further assessment?
Amber flags should also be discussed with a senior colleague and Primary Care Team (GP or HV)

Indicators or Risky Fracture Presentations:

- Any fracture in a non-mobile infant.
- Metaphyseal fractures of any limb bone
- Rib fracture -'high risk'
- Spiral /oblique humeral fractures
- Multiple fractures / different ages

Other Risky Infant Presentations:

- No /Unclear /Changing history
- No ante-natal care
- Passive, watchful, fearful infant
- Delay in presentation
- Injury "caused by sibling "
- Lack of supervision at time of injury
- Attachment difficulties with premature / difficult babies
- Not comforted by parent when distressed (passivity)
- Previous Social Services contact
- Persistent DNAs
- Previous apparently plausible" attendances

Indicators of Risky Bruising Presentations:

- Any bruise in a non-mobile infant (can be a precursor to more serious injury or death) *Remember skin pigmentation / ethnicity may mask bruising*
- Bruising to the face, head (eye socket) back, abdomen, hip, upper arms, backs of legs, ears, hands or feet
- Multiple or clusters of bruising
- Severe bruising to the scalp, accompanied by swelling around the eyes and no skull fracture may result from 'scalping'

Indicators of Risky Burn/Scald Presentations:

- Clear 'tide mark' to limbs or demarcation line
- Bilateral lower limb involvement
- Symmetrical pattern / uniform depth
- Burns to dorsum of hands / soles of feet
- Sparing of the skin folds / centre of buttocks
- Associated injuries
- Evidence of neglect

Parental Risk Factors:

- Domestic violence
- Mental health issues
- Substance misuse
- Learning difficulties
- Social isolation
- Young parents
- Social deprivation / criminality
- Poor parenting experience / LAC

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