



Multi-Agency Guidance for Injuries in NON-MOBILE Babies

Version 2018: South Gloucestershire and Bristol multi agency working group
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Ratified by: South Gloucestershire, Bristol & North Somerset Local Safeguarding
Children Boards
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Following the suspicious 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

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 e.g. 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

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 even 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. Blue spot birth marks are not always present at birth and can develop up to 3 months of age (*please see attached re Characteristics of 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) 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. Photographic documentation by the parents can be very helpful.

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

5. HISTORY OF TRAUMA WITHOUT INJURY

If a baby is presented following a history of trauma they should be checked for injuries. If no injury is observed, professionals do not need to make a referral for checks or examination under this policy. If the history of events or presentation raises any safeguarding concerns, 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 siblings/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 The Children's Emergency Department (ED) with trained paediatric staff, even if there is a plausible explanation.

It may take some time to complete appropriate checks and consideration should be given to allowing the baby home whilst these are undertaken. This decision would ordinarily be with the clinician and this should remain the case, taking into account a full risk assessment of the individual circumstances.

If the injury seems minor (e.g. small bruise in a baby who is otherwise well), 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 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.

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

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 with 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 (arranging an ambulance if necessary) and ensure that parents are also prepared to make their own transport arrangements to return home from hospital. The professional 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 their line manager as a matter of priority. The line manager should contact 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 REFERRAL 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 / Access and Response Team ART / Emergency Duty team 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, 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.

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.

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. (From CED the SW will be updated via the usual notification form)
- 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 Cause

If medical examination raises concern of possible non-accidental injury to the child, this must be pursued as an urgent safeguarding referral under usual child protection procedures.

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 LSCB websites).

RELATED POLICIES, PROCEDURES AND GUIDANCE

- SW Child Protection Procedures <https://www.proceduresonline.com/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/>

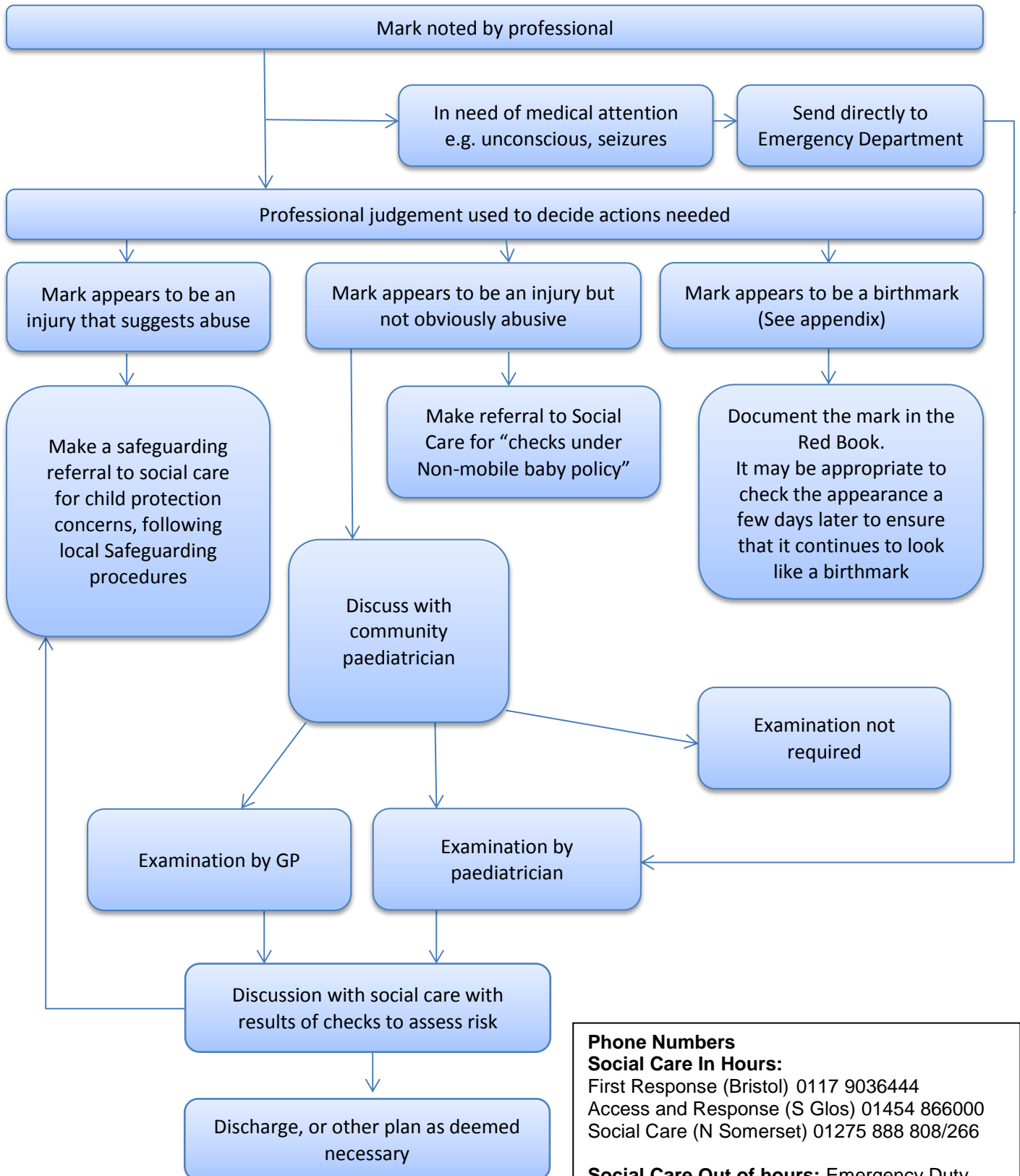
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Flow chart for marks in non-mobile babies



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 Bristol Children's Hospital

Emergency Dept (or to discuss with Consultant Community Paediatrician on-call) 0117 9230000
 Or to **Weston General Hospital** (01934 881340) in office hours

Best Evidence Safeguarding Tool

University Hospitals Bristol 
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 YES
KNOW

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

NO DON'T YES
KNOW

Was I being cared for safely when my accident happened?

NO DON'T YES
KNOW

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 YES
KNOW

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

NO DON'T YES
KNOW

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

NO DON'T YES
KNOW

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

NO DON'T YES
KNOW



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

NO DON'T YES
KNOW

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

NO DON'T YES
KNOW

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

NO DON'T YES
KNOW

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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