DUMFRIES & GALLOWAY
PUBLIC PROTECTION COMMITTEE

Multi-Agency Protocol for Injuries to Non-Mobile Children

Management Information	
Responsible Manager	Policy and Procedures Sub Committee
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Version Control			
Version	**Date**	**Author**	**Comment**

Table of Contents

1. Purpose

1.1. This protocol provides all practitioners with an evidenced-based strategy for the assessment, management and referral of non-mobile children who present with injuries (including bruising or marks).

1.2. Bruising is the most common presenting feature of physical abuse in children. The younger the child, the greater the risk that bruising is non-accidental. There is a substantial and well-founded research base on the significance of bruising in children.

1.3. Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, *must be referred immediately to hospital AND if there is suspicion of abuse must be referred to Social Work* where an Inter-Agency Referral Discussion (*IRD*) will be undertaken within the Multi Agency Safeguarding Hub (MASH) and medical opinion sought.

2. AIM

2.1. The aim of this protocol is to ensure that all professionals and practitioners working within Dumfries and Galloway Multi-Agency Partnership including Health, Social Work, Police, Education and Early Years practitioners and all third sector providers:

- are aware that even minor injuries could be an indication of serious abuse in non-mobile babies,
- know that such injuries, however plausible, must routinely lead to multi-agency information sharing,
- are supported to identify potential concerns and make referrals as appropriate.

3. Scope

3.1. This protocol applies to all professionals and practitioners working within Dumfries and Galloway Multi-Agency Partnership and includes Health, Social Work, Police, Education and Early Years practitioners and all third sector providers.

4. Definitions

4.1. **Baby:** This protocol 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.

4.2. **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 practitioners can use their professional judgement and/ or discuss with a senior manager as to whether the child requires a referral and/ or examination by a Paediatrician or not.

4.3. **Mobile:** Babies who can crawl, pull to stand, 'cruise' around furniture, or are toddling.

4.4. **Non-mobile:** Babies who are not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Babies who can roll are classed as non-mobile for the purposes of this document. Practitioners must use their judgement regarding babies who can sit independently but cannot crawl, depending on severity of the injury and its plausibility. This protocol also applies to older children with impaired or reduced mobility due to disability or illness.

4.5. **Key:**

ED – Emergency Department

MASH – Multi-Agency Safeguarding Hub

IRD- Inter Agency Referral Discussion

GP – General Practitioner

SAP – Single Access Point

RFA – Request for Assistance

DGPPP – Dumfries and Galloway Public Protection Partnership

NAI – Non-Accidental Injury

OOH SW – Out of Hours Social Work

HV – Health Visitor

FN – Family Nurse

DGRI – Dumfries & Galloway Royal Infirmary

5. Background

5.1. Research and findings from learning reviews across Scotland and the UK have found when a baby has died under suspicious circumstances, there have often been a number of instances

where the baby has been presented to practitioners prior to their death with what appeared to be potentially plausible, accidental or minor injuries. Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission.

5.2. Non-mobile babies cannot cause injuries to themselves and therefore must be considered at significant risk of abuse. Multi-Agency information sharing is essential to allow for timely, informed judgements to be made regarding a child's safety.

5.3. "If they don't cruise, they don't bruise."

6. Policy

6.1 PROFESSIONAL JUDGEMENT

6.1.1 This document is written on the understanding that practitioners are allowed to use their professional judgement. 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 practitioners can be falsely led by seemingly plausible explanations.

6.1.2 Even senior, experienced practitioners 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 child protection lead/ co-ordinator or a Consultant Paediatrician. Practitioners in education should discuss any potential injury in a non-mobile child with their child protection lead immediately. Social Work and Police checks should still be undertaken even if the cause of the injury is thought to be accidental to inform decision making. Practitioners not working in health as well as those in health should ALWAYS discuss an injury in a non-mobile baby with a Paediatrician as soon as possible.

6.2 CONFIRMATION BIAS

6.2.1 Confirmation bias is the tendency to only attend to and take into account the information that confirms our preconceptions or previous assessments. This means that practitioners may be sceptical of information that conflicts with their views and instead they actively look for evidence that supports their thinking. Confirmation bias is common amongst practitioners working with children or young people and their families. For example,

practitioners can develop 'tunnel vision' towards the goal of reunification and will ignore, minimise or fail to consider concerns as they arise. Similarly, a practitioner who supports the continuation and support of a placement may ignore or minimise mounting concerns about the child or young person's safety. Consultation, reflective practice and supervision minimise the risks associated with confirmation bias.

6.3 RULE OF OPTIMISM

6.3.1 Practitioners want to believe that what they are doing is working and that they are making a positive difference for children and young people. The rule of optimism can blind them to what is really going on. It leads them to believe that they are seeing progress, even if in reality little change has been achieved. There may be too much emphasis on strengths and less attention paid to areas of concern. The rule of optimism may mean practitioners have an overly positive interpretation or assessment of a situation and ignore or discount the impact of valid concerns, e.g. bruise in a non-mobile child with parents who appear to be loving and caring, who live in a clean warm home and with professional occupations.

6.4 GROUP THINK

6.4.1 Practitioner groups tend to conform and group think occurs when the desire for cohesiveness within a staff group produces a tendency to agree with each other to minimise conflict and to reach consensus without critical evaluation. Practitioners can avoid raising opinions, issues or alternative solutions to maintain harmony. Multi and single agency teams need to be conscious of the risk of groupthink and ensure that staff are empowered to raise concerns, voice differences of opinion and use escalation processes as appropriate.

6.5 BENIGN SKIN MARKS

6.5.1 This protocol refers **only** to injuries. Midwives/ Paediatricians should check for any injuries that have occurred as a result of the birth itself and record this in the clinical notes as well as the Parent Held Record (Red Book) so other practitioners can see this information (with parental permission).

6.5.2 Where it is believed a skin mark could be a birth mark or similar benign medical skin condition, practitioners should be encouraged to use their professional judgement. Blue spot birth marks are not

always present at birth and can develop up to 3 months of age. Where a suspected birth mark is identified post birth and the baby is in hospital, the mark should be reviewed by a Paediatrician and if confirmed, documented in the clinical record and Red Book.

6.5.3 In the community if a practitioner suspects a birth mark the baby's parents/ carers should be requested to seek a medical opinion from their GP without delay. This may require the practitioner contacting the GP surgery to facilitate an appointment within an appropriate timescale (see Appendix 1) and the practitioner should follow up with the GP the findings of any consultation. Photographic documentation by the parents can be very helpful (see Appendix 2). Early Years practitioners who identify a mark which appears to be a birthmark may be able to quickly ascertain with a health visitor as to whether this is a birthmark which has been previously confirmed by a medical practitioner. However, Early Years practitioners should not unduly delay seeking the opinion of a GP or Paediatrician if they are unable to contact a health visitor promptly.

6.5.4 Any birth marks confirmed by the Paediatrician or by the GP whilst under midwifery care should also be recorded at the midwife to HV/ FN handover and the HV/ FN should document the mark on the baby/ child body diagram on Morse.

6.5.5 Social Work and Police checks should not be undertaken if it is ascertained that the mark is a birth mark.

6.6 HISTORY OF TRAUMA WITHOUT INJURY

6.6.1 If a baby is presented following a history of trauma (e.g. a fall from a pram/bed) they should be checked for injuries by the appropriate health professional. Where there are concerns about the baby requiring urgent medical attention then the practitioner should contact 999.

6.6.2 If no injury is observed practitioners do not need to make a referral to Social Work under this protocol. However, if the history of events or presentation raise any child protection concerns, including concerns about supervision or parental care, practitioners should follow the local child protection procedures and complete appropriate referrals. Where the child's name is on the Child Protection Register or they are Care Experienced a referral to SW should be made for tripartite consideration within the MASH.

6.7 NON-MOBILE BABIES PRESENTING WITH AN INJURY

6.7.1 Any non-mobile baby with an injury requiring medical treatment should be seen without delay at DRGI including those with bleeding from the nose, mouth and/or ear. Out with the hospital, if urgent medical attention is required then the practitioner should call 999. Where a child under 1 year of age with an injury presents to the Emergency Department, he/ she must be seen by a senior doctor as per the guidelines for ED staff in Appendix 4.

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

6.7.3 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.

6.7.4 It is fundamental that the assessment of the family and 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.**

6.7.5 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.

6.7.6 Due to the significant risk of any injury being the result of abuse in a non-mobile baby **ALL non-mobile babies with an injury** should be discussed with a Paediatrician, even if there appears to be a plausible explanation. A discussion should also take place at this early stage with Social Work to establish an interim safety plan including the need for any immediate supervision of the parent/ carer with the child and arrangements for safe transfer to hospital.

6.7.7 If the baby has a mark or injury and appears clinically well (e.g. bruise in a baby who is otherwise well), the practitioner should contact the on-call Consultant Paediatrician without delay (via DGRI switchboard 01387 246246) to discuss the baby rather than send them immediately to hospital. If an examination is required, it

will be arranged for the same day/within 24 hours. Consultant Paediatricians have the right to use their professional judgement when considering injuries in non-mobile babies. If there is any uncertainty practitioners should always discuss the baby with the on-call Paediatrician.

6.7.8 If the Consultant Paediatrician requests to see the baby the practitioner should then inform the baby's parent/ carer that a person with parental responsibility will be required to attend hospital with their baby or at the very least give consent for a medical examination to take place. The practitioner should provide the 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.

6.7.9 The practitioner identifying the concern should, as part of their explanation about what happens next, give parents/carers the information leaflet about Bruising and Injuries in Babies and Children (Appendix 3). All parents should have received antenatal and postnatal information from the Midwife and Health Visitor or Family Nurse about keeping baby safe, which includes an overview of what will happen if there is a bruise or mark on a non-mobile child.

6.7.10 The practitioner should discuss with the parent/ carer how they will get to hospital, arranging an ambulance if necessary. The practitioner should inform the Paediatrician of approximate timescales for hospital attendance. Where a baby has not attended hospital with the parent or carer within a reasonably expected time, the Paediatrician should inform Social Work of the delay in arrival. Consideration should be given to the need for a chaperone if there are concerns regarding risk of flight, further harm and/ or where parents/ carers are unwilling or unable to safely and reliably transfer the baby to hospital. Where there are concerns the practitioner referring to the Paediatrician should also liaise with Social Work to agree an interim safety plan.

6.7.11 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 practitioner should discuss the matter with their line manager as a matter of priority. The line manager should contact the Consultant Paediatrician on call to discuss and agree next steps.

If an examination is deemed necessary, Social Works' immediate involvement is essential, and a referral should be made by the attending practitioner. This allows for interim safety arrangements to be considered, including safe transportation to hospital.

6.8 MAKING A REFERAL TO SOCIAL WORK

6.8.1 Where a decision to refer is made, it is the responsibility of the identifying practitioner to learn of or observe the injury to make the referral. In some situations, e.g. a nursery setting, staff may want to seek the support of their line manager, but this should not cause any undue delay in referring.

6.8.2 The practitioner must contact the Social Work Single Access Point (SAP) and share details with Social Work where known, including names and DOBs of all residents in 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, or around the time of the incident (e.g. parents partner, grandparents, other family members). Staff should also share any known details of siblings and step siblings or other children in the home to inform interim safety planning for all relevant children.

6.8.3 All telephone referrals to Single Access Point/ Social Work must be followed up within 24 hours with a written referral using the appropriate referral form.

SAP contact no. Mon-Friday 9-5pm Tel: 030 33 33 3001 and Out of Hours Tel: 01387 273660.

6.8.4 The parent/ carer should be informed that all non-mobile babies with any injury require standard record checks with Social Work, Health and Police to establish whether any person or situation posing a known risk to children is present in the household.

Practitioners should make clear to Social Work they are making a child protection referral and follow up in writing as soon as practically possible. A chronology entry should be made in the child's record.

6.8.5 Social Work should be made aware of the events, the explanation given by the parent/ carer, 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 within MASH. The safety and whereabouts of other children in the family must be considered.

6.8.6 Staff can refer to the Child Protection Assessment Tool to support their initial assessment and referral to Social Work (Appendix 2).

6.8.7 Parents should be provided with the DGPPP Bruising and Injuries in Babies and Children information leaflet (Appendix 3).

6.9 OUT OF HOURS ARRANGEMENTS

6.9.1 When a non-mobile child with an injury or mark is admitted to hospital out with working hours the Paediatrician/ ward staff will notify OOH SW by telephone call followed by submission of a Request for Assistance Form. Social Work will liaise with the Police to arrange a tripartite meeting between the Paediatrician, Police and Social Work to agree any immediate actions and safety plan with respect to the child or any other relevant children or vulnerable adults. Social Work will take a note of the meeting which should include a summary of the discussion and agreed plan. Copies of the note should be emailed to Police and Health as soon after the meeting as possible to ensure that all agencies have a copy of the agreed safety plan for their records.

6.9.2 Police copies should be sent to DumfriesGallowayConcernHub@scotland.police.uk and DumfriesGallowayPublicProtectionUnit@scotland.police.uk and to the email address of the Police Officer attending the meeting.

6.9.3 Health copies should be sent to dg.childprotectionteam@nhs.scot and dg.ward15@nhs.scot and to the email address of the Paediatrician attending the meeting.

6.9.4 Once agreed, the final note should be stored in each agency's records. It is the responsibility of the professionals attending the meeting to ensure appropriate record keeping within their respective agency.

6.10 MULTI-AGENCY SAFEGUARDING HUB AND INITIAL REFERRAL DISCUSSION

6.10.1 Injuries in a non-mobile child should raise immediate suspicion of abuse and should result in an immediate telephone referral to Social Work and/ or Police who will arrange an IRD through the Multi Agency Safeguarding Hub.

6.10.2 As soon as any agency becomes aware of a possible injury in a non-mobile child, the agency in receipt of the information should initiate a MASH huddle. This should be held as soon as possible and the health advisor on MASH should invite the on-call Consultant Paediatrician to attend. The MASH huddle will agree any immediate actions including safety planning for the child during travel to hospital, initial medical examinations, immediate safety of siblings, timing of IRD, interim overnight safety planning if required and the need to initiate any immediate Police inquiries.

6.10.3 Additionally, the MASH huddle should consider whether the parents/ carers are vulnerable adults who may also be in need of support and protection and undertake a joint adult/ child IRD where required.

6.10.4 An Inter Agency Referral Discussion (IRD) should be undertaken in all cases where there is an injury to a non-mobile child. The on-call Consultant Paediatrician should be invited to attend the IRD and should join the IRD where possible. If the Paediatrician is not able to attend the IRD the Health Public Protection Advisor in MASH should inform the Consultant Paediatrician of the outcome of the IRD. The decision/ outcome of the IRD can be paused to allow for any Forensic Medical/ Examination to be undertaken and the outcome reported back to MASH or OOH SW. However, this should not delay an immediate safety plan being agreed and put in place. The IRD should also consider safety planning for any siblings or other relevant children who may be at risk of harm.

6.10.5 The IRD should consider whether any siblings or other relevant children may require a single doctor or Forensic Medical Examination, taking into account the presenting concern, multi-agency information and analysis at IRD, and the age and developmental stage of each child. The ultimate decision as to whether or not to undertake medical examinations is that of the Consultant Paediatrician. It is the responsibility of the Consultant Paediatrician to decide which additional medical tests and scans should be undertaken for all children discussed at IRD.

6.10.6 It is the responsibility of the Police to arrange any Forensic Medical Examinations in liaison with the Forensic Examiner and the Consultant Paediatrician. It is the responsibility of Social Work to inform the parents/carers of the outcome of the IRD.

6.10.7 Following the IRD, SW will feedback to Education staff and Health Advisors will feedback to relevant Health staff. Where the referrer is an Early Years practitioner, SW will provide feedback.

6.11 THE MEDICAL EXAMINATION

6.11.1 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.

6.11.2 The health assessment of a child for whom there are child protection concerns is to:

- establish what immediate treatment the child may need,
- provide a specialist medical opinion on whether or not child abuse or neglect may be a likely or unlikely cause of the child's presentation,
- support multi-agency planning and decision making,
- establish if there are unmet health needs, and to secure any on-going health care investigations, monitoring and treatment that the child may require,
- listen to and to reassure the child,
- listen to and reassure the family as far as possible in relation to longer-term health needs.

6.11.3 The decision to carry out a medical assessment and the decision about the type of medical examination is made by a Paediatrician, informed by multi-agency discussion with Police, Social Work and other relevant health staff or within a MASH discussion or IRD.

6.11.4 Through careful planning, the number of examinations will be kept to a minimum. The decision to conduct a medical examination may:

- follow from a MASH Discussion or IRD with inter-agency agreement about the timing, type and purpose of assessment,
- following a referral from any agency regarding suspected Non-Accidental Injury (NAI).

6.11.5 The main types of medical examination that may be undertaken within the Child Protection process will be decided by the Consultant Paediatrician and are:

a) Joint Paediatric Forensic Examination (JPFE) -an examination undertaken by a Paediatrician and a forensic physician. This is the usual type of examination for sexual assault and is often undertaken for physical abuse, particularly babies with injuries or older children with complex injuries.

b) Single doctor examination.

c) Specialist Child Protection Paediatric/ Single Doctor/ Comprehensive Medical Assessment. This type of examination is often undertaken when there is concern about neglect and unmet health needs but may also be used for physical abuse and historical sexual abuse.

6.11.6 All medical examinations/ assessments are holistic, comprehensive assessments of the baby's health and developmental needs. The purpose of the examination must be clear prior to the examination (usually discussed at MASH discussion or IRD or at the time of referral for the examination) to allow for a clinician with the appropriate skill set to undertake the assessment.

Following the medical examination, the Paediatrician and Forensic Medical Examiner will verbally inform Police and Social Work of the findings and the Paediatrician will provide Police and Social Work with an initial written summary.

6.12 ACCIDENTAL CAUSE

6.12.1 If the cause of the injury is felt to be accidental, the Paediatrician should still ensure that an IRD is undertaken where all members of the household of non-mobile babies and any other relevant family members are discussed by all agencies within the MASH.

6.12.2 If information shared within the IRD increases concerns that the baby has been abused/ neglected or is at risk of significant harm, the Multi-Agency Child Protection Procedures should be followed.

6.12.3 The Consultant Paediatrician must inform the parents, referring practitioner, Primary Care, Police and Social Work (and other practitioners as appropriate such as named person) of the outcome of the medical examination in writing and of any support/protection intervention required and or being taken.

6.13 NON-ACCIDENTAL AND POSSIBLE NON- ACCIDENTAL CAUSE

6.13.1 If medical examination raises concern of possible non-accidental injury (NAI) to the child, this must be pursued as an urgent child protection matter under local child protection procedures.

6.13.2 A provisional summary report of the examination and any findings should be provided in writing as soon possible after the examination is complete. The provisional report will be shared by the Consultant Paediatrician with the multi-agency team supporting the child and family, primarily health lead professional, Social Work and Police using the ratified national West of Scotland Proforma.

6.13.3 A pre discharge meeting should take place before the child/ family leave the hospital ensuring all multi agency partners are updated and a safety plan collectively agreed.

Any agreed safety plan should be adhered to until all forensic examinations undertaken have been reported on, including repeat skeletal surveys and any secondary reporting by NHS Greater Glasgow and Clyde radiology department.

6.13.4 The Consultant Paediatrician should make it known to Social Work colleagues at the pre discharge meeting which examinations are being undertaken with some indication of timescales for reporting results.

6.13.5 Disagreement between professionals regarding the safety of a child must be resolved using relevant escalation procedures and outcome clearly documented within single agency records.

6.13.6 It is the responsibility of the Consultant Paediatrician, or a designated member of their medical team, to share relevant findings of any ongoing medical investigations with Social Work, Named Person in Health and Police colleagues as they are known in order to inform the multi-agency safety plan and any ongoing Police investigation. The Consultant Paediatrician will use their professional judgement as to the urgency with which new information is shared with Police, Health and Social Work colleagues. For non-urgent results, the Consultant Paediatrician can contact Social Work via the SAP AccessTeam@dumgal.gov.uk or if needing to share information/ test results urgently by calling SW SAP on 030 33 33 300, 9-5pm or out with working hours on Tel: 01387 273660. Police can be contacted via the Risk and Concern Hub email box for non-urgent updates, DumfriesGallowayPublicProtectionUnit@Scotland.police.uk noting that the email is for the Senior Investigating Officer or their deputy, and for more urgent updates by calling 01387 242338 to speak to a Detective. If the Paediatrician is unable to get an answer, or to

share information out with working hours, the Paediatrician can contact Police on 101 asking for the Duty Detective Sergeant or Duty Detective Constable who will update the Investigating Officer.

7. Legislation and Policy Context

7.1 RELATED POLICIES, PROCEDURES AND GUIDANCE

- Bruises on children (CORE-INFO leaflet) (nspcc.org.uk)
- Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE
- Bruising in non-mobile infants (publishing.service.gov.uk)
- Child-Protection-Evidence-Chapter-Bruising_Update_final.pdf (rcpch.ac.uk)

7.2 RESEARCH

1. Maguire S, Mann MK, Sibert J, Kemp A. Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? *Archives of Disease in Childhood* 2005; **90**:182-6
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4. McIntosh N, Mok JY, Margerison A Epidemiology of orinasal haemorrhage in the first 2 years of life: implications for child protection. *Paediatrics* 2007; **120**(5):1074-8
5. Shantini Paranjothy, David Fone, Mala Mann, Frank Dunstan, Emma Evans, Alun Tomkinson, Jonathan Sibert and Alison Kemp. The incidence and aetiology of epistaxis in infants a population based study. ADC online 8th January 2009
6. Shreiti Agrawal et al. Prevalence of Retinal Haemorrhages in Critically Ill Children. Paediatrics 2012; **129**;e 1388
7. T. Sieswerda – Hoogendocrn et al. European Journal of Paediatrics 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

8. Appendices

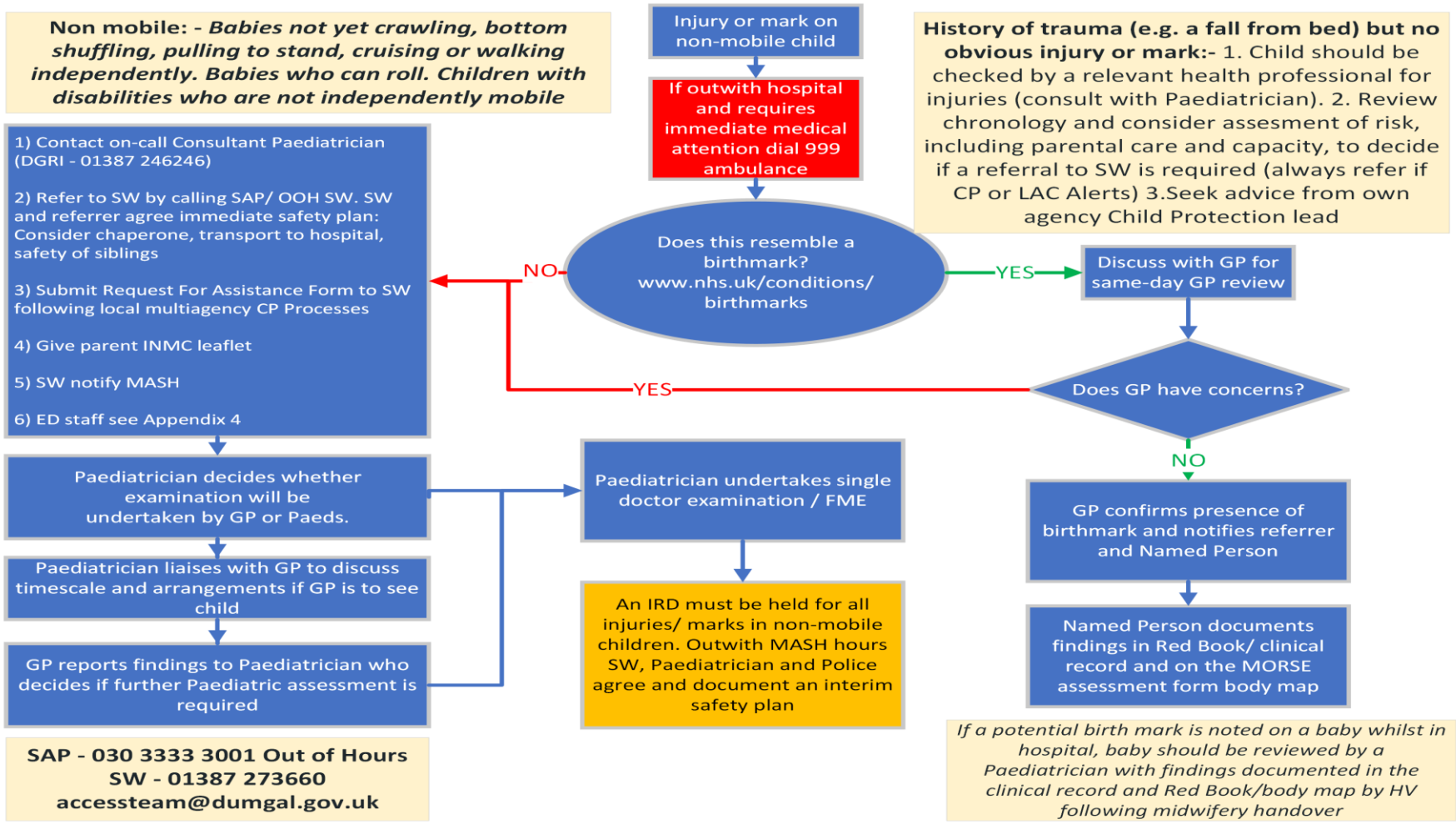
Appendix 1 – Flow Diagram

Appendix 2 - University Hospitals Bristol NHS Trust *Best Evidence Safeguarding Tool* (amended)

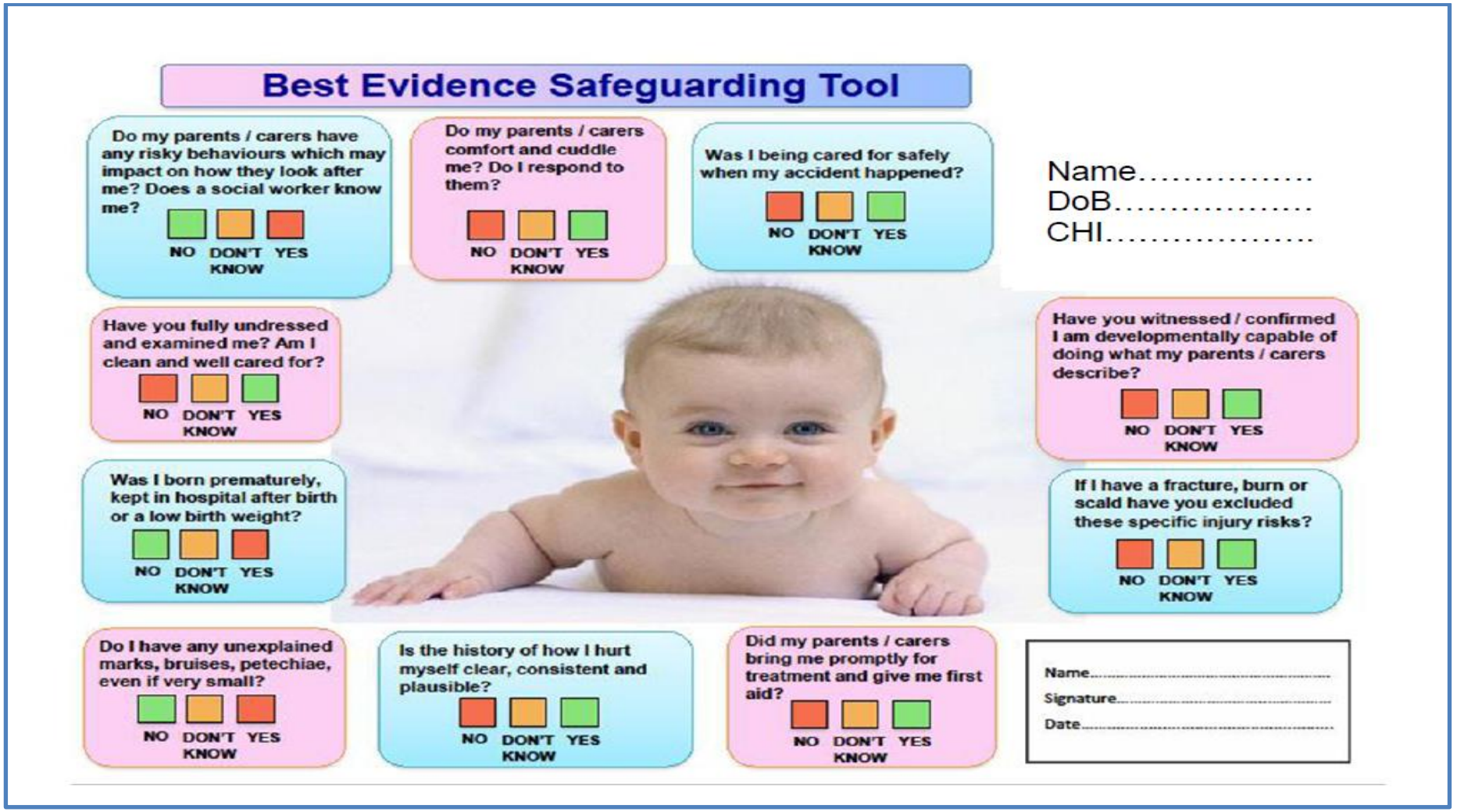
Appendix 3 - D&G Public Protection Partnership Leaflet

Appendix 4 - Children presenting to the Emergency Department with injuries

Appendix 1


Non mobile: - Babies not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Babies who can roll. Children with disabilities who are not independently mobile
Injury or mark on non-mobile child
If outwith hospital and requires immediate medical attention dial 999 ambulance
History of trauma (e.g. a fall from bed) but no obvious injury or mark:- 1. Child should be checked by a relevant health professional for injuries (consult with Paediatrician). 2. Review chronology and consider assesment of risk, including parental care and capacity, to decide if a referral to SW is required (always refer if CP or LAC Alerts) 3.Seek advice from own agency Child Protection lead
Does this resemble a birthmark? www.nhs.uk/conditions/birthmarks
NO
YES
Discuss with GP for same-day GP review
Does GP have concerns?
YES
NO
1) Contact on-call Consultant Paediatrician (DGRI - 01387 246246)
2) Refer to SW by calling SAP/ OOH SW. SW and referrer agree immediate safety plan: Consider chaperone, transport to hospital, safety of siblings
3) Submit Request For Assistance Form to SW following local multiagency CP Processes
4) Give parent INMC leaflet
5) SW notify MASH
6) ED staff see Appendix 4
Paediatrician decides whether examination will be undertaken by GP or Paeds.
Paediatrician undertakes single doctor examination / FME
Paediatrician liaises with GP to discuss timescale and arrangements if GP is to see child
GP reports findings to Paediatrician who decides if further Paediatric assessment is required
An IRD must be held for all injuries/ marks in non-mobile children. Outwith MASH hours SW, Paediatrician and Police agree and document an interim safety plan
GP confirms presence of birthmark and notifies referrer and Named Person
Named Person documents findings in Red Book/ clinical record and on the MORSE assessment form body map
SAP - 030 3333 3001 Out of Hours
SW - 01387 273660
accessteam@dumgal.gov.uk
If a potential birth mark is noted on a baby whilst in hospital, baby should be reviewed by a Paediatrician with findings documented in the clinical record and Red Book/body map by HV following midwifery handover

Appendix 2 – University Hospitals Bristol NHS Trust *Best Evidence Safeguarding Tool* (amended)



Guidance Notes for amended Best Evidence Safeguarding Tool

Please answer all questions by ticking the corresponding box

If the infant has any red flags please discuss with your Child Protection Lead within your own agency and or consider referral to Social Work.

Amber flags should also be discussed with a senior colleague, GP, HV and or Child Protection Advisor

Indicators of Risky Fracture:

- 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

Indicators of Risky Bruising:

- Any bruise in a non-mobile infant (can be 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'

Parental Risk Factors:

- Domestic violence
- Mental health issues
- Substance misuse
- Learning difficulties
- Social isolation
- Young parents
- Social deprivation/ criminality
- Poor parenting experience/ Care Experienced (Previously known as LAC)

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 Work contact
- Persistent DNA
- Previous apparently plausible" attendances

Indicators of Risky Burn/Scald:

- 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
- Evidence of neglect

Developed by Carol Sawkins (2016), Nurse Consultant Safeguarding Children
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Appendix 3 – D&G Public Protection Partnership Leaflet

What will the Paediatrician do?

The Paediatrician will ask you all about your baby/child. This will include when the bruise or injury was first noticed and if you know how it happened.

The Paediatrician will do a full examination which includes undressing your baby/child. The Paediatrician will discuss the outcome of their assessment with you. They may ask for your consent as the parent or carer to perform other examinations or tests.

Your baby/child may require further tests or investigations such as x-rays, and/or bloods tests. This is to ensure there is no underlying medical condition or signs of a non-accidental injury.

Your baby/child may need to stay in hospital while these tests/investigations are being carried out.

If x-rays are required they may need to be repeated again in 2 weeks.

If you have any questions or do not understand anything please ask.

What happens next?

The Paediatrician will speak to the Social Work Department and let them know the outcome of your baby/child's assessment. The Paediatrician might also need to speak to the Police. In the Multi Agency Safeguarding Hub (MASH) a Police Officer, Social Worker and member of NHS Public Protection Team will discuss and jointly decide whether any further action is needed.

Social Work will update you on the outcome of the MASH discussion and advise if any further action is needed.

For further information and Support please contact:

Locality Social Work - Tel: 0303 333 3000
Social Work Out of Hours - Tel: 01387 273660

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DUMFRIES AND GALLOWAY PUBLIC PROTECTION PARTNERSHIP

Bruising and Injuries in Babies and Children

Information for parents and carers about bruising or injuries on babies and children who are not independently mobile

This leaflet explains the process that Dumfries and Galloway Public Protection Partnership must follow for babies/children living in Dumfries and Galloway when a bruise, injury or mark has been noticed on your baby or child.

All professionals working with babies and children are expected, as part of their professional duties, to ensure babies and children are kept safe from harm.

If you do not understand any part of the process and need further explanation, then ask the professionals involved who can then provide you with further information.

Why is bruising in babies and non-mobile children such a concern?

Bruising in babies or children who are not crawling is unusual and not common.

It is very unusual for a baby to get a bruise during everyday activities such as nappy changing, bathing or feeding.

But I have explained how I thought this happened.

Even when babies and non-mobile children fall or get knocked, it is unusual for them to get injured or bruised.

Bruising can be related to a health condition which has not been previously identified, and further medical assessments may be required.

Sometimes bruising in babies or non-mobile children is due to a deliberate injury. Even where there is an explanation it is important for professionals to make further enquiries.

Your baby or child will still need to be carefully assessed. It can take an opinion from a Consultant Paediatrician (specialist children's doctor) to be able to tell the difference between bruises and other types of marks.

This is very upsetting for me. Why do I/we have to be put through this?

We understand this can be very upsetting, but the only way of picking up serious causes for bruising or injuries is to investigate every case when it occurs.

However you can be reassured that you will be treated with courtesy and sensitivity and your explanations will be listened to and discussed with you. You will be kept informedat all times so that you know what is going on and why. You can ask questions at any time and will be given the opportunity to discuss your concerns fully at every stage.

What happens now?

1. A request will be made for an examination by a health professional at Dumfries and Galloway Royal Infirmary (DGRI) or in some cases the on-call Paediatrician may ask your GP to see the child.

2. A referral will be made to Social Work.
3. Your baby or child will be discussed with Health, Police and Social Work. This is called the MASH team. Part of the assessment involves gathering information from other agencies who may hold information about your family or who may be working directly with you.

This will be arranged as soon as possible.

Appendix 4 – Children presenting to the Emergency Department with injuries