NHS Lothian

Title: **Child Protection Protocol for the management of unexplained bruising in pre-mobile babies**			
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Approved by:	Public Protection Action Group (PPAG)		
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Executive Lead:	Executive Director of Nursing, Midwifery, and Allied Health Professionals		
Target Audience:	All medical and nursing staff in the Emergency Department, all paediatric wards, Community Child Health, and community-based staff working with young infants and babies		
Supersedes:	Child Protection Protocol for the Management of Unexplained Bruising in Non-Mobile Babies 2016		
Keywords (min. 5):	Unexplained Bruising, Pre-mobile babies, Child Protection, Abusive Head Trauma, Inter Agency Referral Discussion		

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Version Control

Date	Author	Version/Page	Reason for change
28/04/20	Consultant Paediatrician, Child Community Health	1.1/throughout	Update from GP review- includes explanation of acronyms & keywords
06/05/20	Consultant Paediatrician, Child Community Health	Final	Updated from PPAG

Child Protection Protocol for the management of unexplained bruising in pre-mobile babies

NHS Lothian

Contents

1.0 Purpose

The purpose of this protocol is to protect babies from significant physical harm.

The medical evidence around inadequately or un-explained bruising in pre-mobile (not crawling, cruising or walking) babies is clear. Although the baby cannot tell us what has happened, we know that bruising is strongly related to mobility; bruising in a baby with no independent mobility is very uncommon[1, 2, 3, 4]

We risk missing more serious later abuse if we fail to act on bruising in pre-mobile babies, which can be a sentinel sign of abuse, with possible fatal consequences.[5, 6] In other words bruises in pre-mobile babies can be a warning sign of future abusive head trauma which can cause brain injury and/or death in the majority of cases.[7]

The pattern of bruising can indicate an increased likelihood of abuse. Abusive bruises are more common on the ear, face, neck, torso and buttocks.[2] Of note, only 5% of accidental bruising is found on the cheeks.[8, 9]

2.0 Scope

A protocol for the management of all pre-mobile babies presenting to staff with unexplained bruising.

However if the baby or child is older and mobile, but you still have concerns around the presentation of the bruising, either due to its inadequacy of explanation, pattern, or distribution/quantity, this protocol can still help guide a sensible approach while assessment takes place.

3.0 Definitions

Pre-mobile babies are not crawling, cruising (walking holding onto the furniture), or walking.

JPFE: Joint Paediatric Forensic Medical Examination

IRD: Inter Agency Referral Discussion

GIRFEC: Getting it Right for Every Child

4.0 Roles and responsibilities

The pre-mobile bruising protocol should be consultant led throughout, although delegation of tasks to other health professionals is appropriate with consultant agreement and supervision.

There are specific tasks outlined in the protocol for any professional raising concerns after initial contact with a baby, and for staff working in the Emergency Department, Acute Receiving Unit, Child Protection Hub and Radiology, as well as guidance for the child protection Inter-agency partners.

5.0 Main content

When a pre-mobile baby presents with an inadequate or no explanation for a cause of bruising, the following protocol (with responsibilities identified at different stages of the pathway) should be followed: (see Flowchart D under item 6.0)

Initial concern presenting to a professional

1. Initial concern of bruising in pre-mobile baby noted (Health visitor or nurse/GP/Nursery staff/Social worker/other professionals)
2. Professional explains the concern for baby and the need for further assessment by a specialist doctor, using **Bruising in Young Babies** leaflet to help with explanation (item 6.0/C)
3. Ensure support is provided to family (or ambulance is called) to attend Emergency Department
4. Contact NHS Lothian Child Protection Hub to discuss plan (0131 536 0467) or Out Of Hours "Paediatrician on call for child protection" (0131 536 0000)

Emergency Department (overseen by ED consultant or paediatrician at St John's)

1. Assess baby for any immediate health needs (for example risk of sepsis)
2. Gather presenting history and document bruising on a body chart and any other medical or child protection concerns. On TRAK use canned text ***\cpcl THEN space*** on Progress note for guidance (Item 6.0/A)
3. Explain the plan to consider medical causes but also that you are raising a child protection concern as "everyone working with children must follow the guidance when they find a bruise or a mark which appears to be a bruise, in a baby".
4. Gather family/carer and other children's details (names, dates of birth, addresses of adults and children) and feed back to CP Hub/consultant
5. Bloods (priority for blood clotting initially but take as much as possible at this initial stage):
    - **NAI screen (incl FBC + Coag scr) RHSC**
    - Other appropriate investigations (NB consider **sepsis** and differential diagnosis)
    - Renal and Liver function
    - Ca, Mg, Phosphate, Alk Phos, Vit D and PTH
    - NAI Copper caeruloplasmin RHSC
6. Arrange medical admission

ARU team (consultant leading)

1. Admit child taking verbatim history from family and documenting medical assessment (See canned text (6.0/A) if not already done)
2. Admit baby to visible space and discuss with Clinical coordinator or CP consultant regarding level of care required both to facilitate parenting and to ensure baby is safe

3. Discuss and agree with CP consultant around who will give and discuss the **Bruising in Young Babies** and **Skeletal Survey** (SS) leaflets (6.0/C) with the parents/carers, explaining the need for further investigations. Any discussion needs documented on the baby's clinical notes on TRAK.
4. Ensure all investigations completed (6.0/E)
5. Daily top to toe examination on the ward round (to ensure clinical wellbeing and assess if there is an evolving process) and explanation of any normal results and plans for further tests are given to family. Communication from the whole team remains key.
6. A member of the team should attend any discharge planning meeting
7. If any bruises are not fading/resolved by discharge (ensure there is a check done at final ward round), inform CP Hub and discuss a plan for review of bruise(s).

Child Protection Hub (usually led/managed by Consultant) (0131 536 0467)

1. Ensure ED consultant is aware of baby attending if alerted in advance – ask to speak directly to the ED consultant if at all possible
2. Agree plan for initial assessment and blood tests with ED team
3. Ensure there is clarity of communication for baby and his parents/carers, and that they are aware of child protection concern, usually via ED (or ARU) staff explanation. (see ED action 3 above)
4. Raise Interagency Referral Discussion (IRD), either before or after initial ED assessment, including immediate assessment of risk to siblings
5. Ensure baby bruising statement (6.0/B) (or part thereof) is completed on TRAK IRD episode in the **Significant Information box**, with contact details of key professionals for this IRD updated regularly.
6. Discuss with Acute Receiving Unit and Radiology hospital consultants the investigations (6.0/E), sharing of information with parents (see item 7) required and appropriate safety of child in hospital setting
7. Agree with ARU consultant as to who will give and discuss the **Bruising in Young Babies** and **Skeletal Survey** (SS) leaflets (6.0/C) with the parents/carers, explaining the need for further investigations. Any discussion needs documented on the baby's clinical notes on TRAK.
8. At IRD discuss and agree need for Joint Paediatric Forensic Examination (JPFE) and complete this at an appropriate time including consent form.
9. Investigation results are gathered
10. Inform family of child protection results, with support/agreement of other agencies/specialists
11. Opinion should include use of NHS Lothian consensus statement (6.0/B) on baby bruising (if appropriate) on e-IRD to ensure clarity of medical opinion for other agencies
12. Discharge planning with other agencies should include interim safety planning to ensure that the baby and any siblings remain safe.
13. Ensure follow up skeletal survey is requested, put on CP Hub handover sheet, and communicated to other agencies to facilitate attendance

14. If any bruises are not fading/resolved by discharge, link to the JPFE or lead CP consultant for the case and discuss next steps at the discharge planning meeting to consider review

Radiology

1. Discuss appropriate imaging with CP and/or hospital consultant. This should be Skeletal Survey and head imaging. Head imaging will be CT, unless the bruises are likely more than 10 days old where MRI should be performed.
2. Ensure that the TRAK request confirms that the Skeletal Survey leaflet (6.0/C) has been given to family, who assent to imaging
3. Link with CP and hospital teams with opinion and report
4. Ensure follow up Skeletal survey is organised at 11-14 days (if not been done already)
5. Contact CP hub if any bruises noted at time of 2nd skeletal survey

Interagency Referral Discussion priorities (all 3 agencies)

1. Gather background factors to help with initial and ongoing risk assessment
2. Ensure safety of siblings both acutely and ongoing
3. Communicate with all agencies and make plans together at each stage
4. Interim Safety and Discharge planning are key to ensure baby is protected as much as possible while risks are assessed in the early stages of the IRD
5. Ensuring an understanding of all practitioners that the risks may remain regardless of medical tests being normal (such as scans and skeletal surveys)
6. Support family to attend for any further tests including skeletal survey
7. Child Protection Case Conference (CPCC) or GIRFEC planning: The majority will reach the threshold for CPCC (at risk of significant harm). If not, then clearly document on e-IRD the reasons why and ensure GIRFEC (Getting it Right for Every Child) planning is in place.

6.0 Associated materials

A. Canned Text for documenting CP history on TRAK

In progress note: \cpcl THEN space

Child Protection Check List:

Is the following documented as part of the child's ELECTRONIC patient record? – if not, please ensure that it is »

- *Who attends with the child?*
- *A verbatim history of the presenting complaint / circumstances of the injury?*
- *Perinatal History?*
- *Past Medical History?*
- *Family History including coagulation disorder / metabolic bone disease?*

- *Developmental History (particularly gross motor development)?*
- *Social History (include names and dates of birth of parents and who has cared for child recently)?*
- *Any siblings / other children living within the household (include full names and DoB)?*
- *Name of any allocated SW?*
- *If the child is on the child protection register?*
- *Weight / Height / OFC?*
- *General appearance and demeanour?*
- *Full systems Examination?*
- *Top to Toe survey of surface marks and injuries (use body charts from TRAK if required)?*

And complete:

- *A clinical impression and plan?*
- *Has the child protection consultant been informed?*
- *Has a child visiting policy been considered?*

B NHS Lothian Consensus Statement on pre-mobile baby bruising

XX is a pre-mobile baby (i.e. not crawling, cruising or walking). He/she presents with a bruise(s)

- *Describe (number/multiple, location, size, soft tissue, imprint e.g. grip mark, finger tips, implement)*
- *With/without additional injuries, if known*

For which in our/my opinion there is an incompatible/ no explanation.

Accidental bruising in pre-mobile babies is rare.

Bruises in pre-mobile babies are a recognised precursor (can be a warning sign) of future abusive head trauma which causes brain injury and/or death in the majority of cases.

These statements are based on researched evidence which is available at https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising

Therefore based on the information available at this time, our/my opinion is that the injuries to XX are more likely to be non-accidental and XX is at ongoing risk of significant harm. This opinion will be reviewed should further information become available.

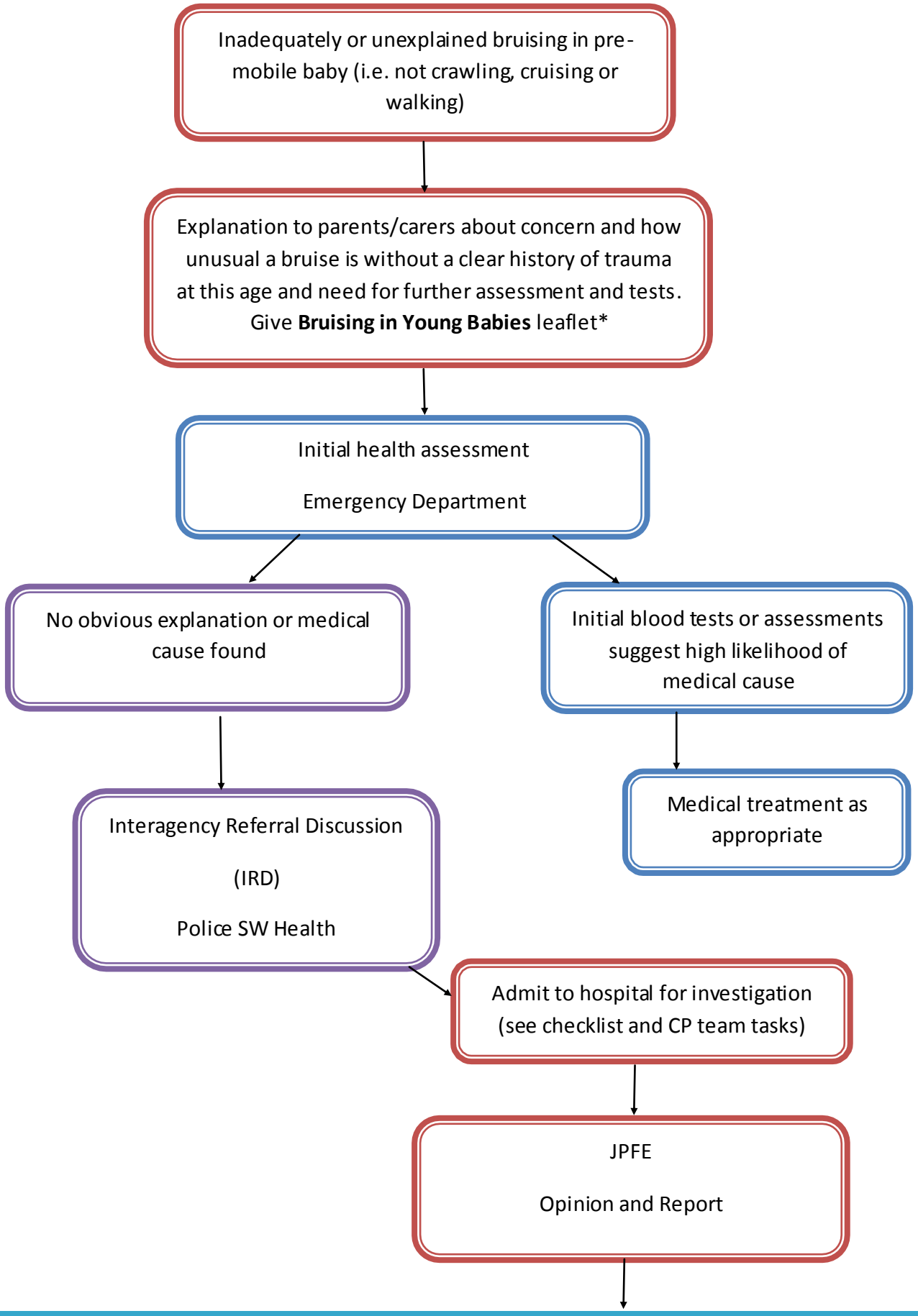
Please contact Child Protection Hub (20467) or child protection consultant on call via switchboard if new concerns arise during this baby's inpatient stay.

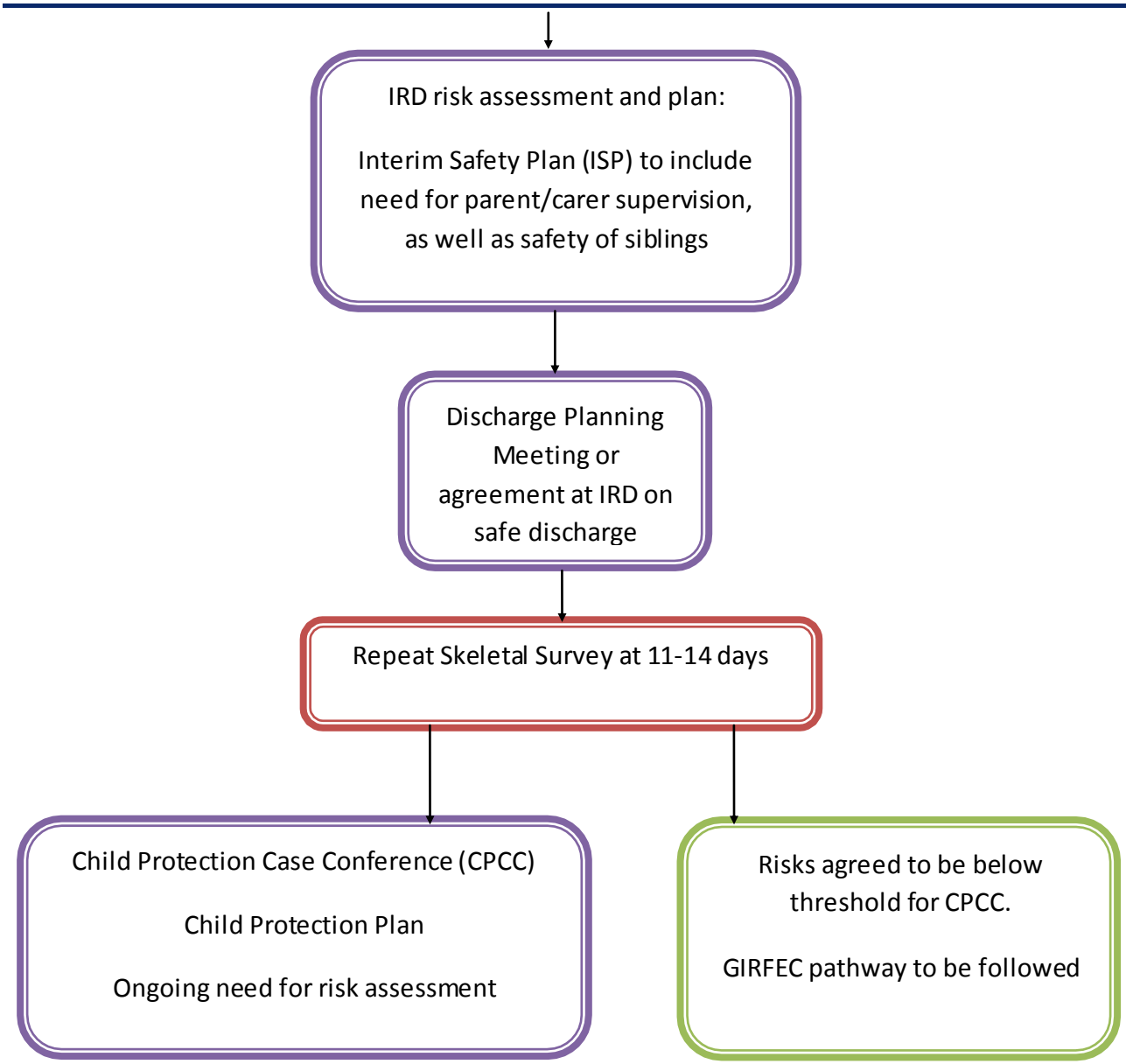
Other agency contact details are as follows:

C. Resources:

- Bruising in Young Babies – Information for parents and carers leaflet (MCN CP)
- Handle with Care – How to keep your baby safe leaflet (NSPCC Need-to-know guides)
- Skeletal Survey – Information leaflet for parents and carers (MCN CP)

A. Unexplained Bruising Pathway in a Pre-mobile baby





* The following resources are available:

- Bruising in Young Babies – Information for parents and carers leaflet (MCN CP)
- Handle with Care – How to keep your baby safe leaflet (NSPCC Need-to-know guides)
- Skeletal Survey – Information leaflet for parents and carers (MCN CP)

B. Checklist of Investigations for Infants Suspected to be at Risk of NAI

Child Protection Paediatrician to advise which are relevant

	Investigation	Date Requested	Result
Radiology	CT Head		
	Skeletal Survey		Name of Radiologist
	MRI Brain and spine		
	Follow up skeletal survey views (11-14 days later)		
Other	Retinal Examination if: 1. Radiological and or clinical evidence of neurological injury (subdural haematoma, brain swelling, brain contusion, etc.) 2. There are rib fractures and /or metaphyseal bone fractures that are typically associated with neurological injury		Name of Ophthalmologist
	Consider Abdominal CT if serious history of trauma and/or abnormal LFTs		
Bloods On TRAK request:	FBC		
NAI Screen (incl FBC + Coag scr) **RHSC**	Coagulation screen		
	Extended NAI Coagulation Screen		
	Blood Culture / CRP/ septic screen		
	Renal and liver function		
	Ca, Mg, Phosphate, Alk Phos, zinc		

	Vitamin D and PTH		
NAI RHSC	NAI Copper, caeruloplasmin RHSC		
Urine	Urine toxicology		
	Further metabolic tests if indicated (OA if large head for instance)		

7.0 Evidence base

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8.0 Stakeholder consultation

Community Child Health paediatricians

Emergency Department clinicians

ARU paediatricians

Radiology

Ophthalmology

Midwives, Health Visitors and Family Nurses

General Practitioners

Inter-agency Partners

9.0 Monitoring and review

Annual Baby Bruising audit and report to Child Protection MCN

Review in 3 years