**Regional Child Protection Procedures for West Midlands**

**2.26 Injuries in Babies and Children under 2 years of age**

**Contents**

* [Practice Guidance for Assessment, Management and Referral(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4973)
* [Introduction(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4974)
* [Definitions/Scope of Guidance(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4975)
* [What to do if any type of injury (including bruises) are seen on a non-mobile child/baby or there are concerns about non-accidental injury in a child under 2 years(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4976)
* [Responsibility of Children’s Services(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4977)
* [Responsibility of On call Paediatrician(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4978)
* [References/Resources(Jump to)](https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4979)

**Practice Guidance for Assessment, Management and Referral**

The aim of this guidance is to support practitioners by providing guidance about the management and referral of babies and children under the age of 2 years, particularly those who are not yet independently mobile, who have presented with an injury.

**It does not replace the process to be followed once a referral to Children’s Services has been made.**

|  |
| --- |
|  |

**Introduction**

Children under the age of 2 years are at an increased risk of serious physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) and are rarely able to communicate the history themselves. Non-inflicted injuries in non-mobile infants are unusual.  Children with a disability who are not able to move independently are also at risk of serious physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51).

Even small injuries may be significant and may be a sign that there is another injury that is not visible e.g. fracture in an infant with a small bruise.  They may also be a “sentinel injury”; i.e. an injury that, if not recognized as possibly inflicted and acted upon, is associated with later severe or fatal maltreatment.

Features in the history that raise suspicion of physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) include:

* A significant injury where there is no explanation.
* An explanation that does not fit with the pattern of injury seen.
* An explanation that does not fit with the motor developmental stage of the child.
* Injuries in infants who are not yet independently mobile.
* An explanation that varies when described by the same or different parents/carers.
* Multiple explanations that are proposed but do not explain the injury sustained
* Delay in seeking medical attention – delayed presentation
* An inappropriate parent or carer response e.g. unconcerned or aggressive.
* A history of inappropriate child response (e.g. didn’t cry, felt no pain)
* Presence of multiple injuries
* Child or family known to children’s social care or subject to a [Child Protection Plan](https://westmidlands.procedures.org.uk/page/glossary?term=Child+Protection+Plan&g=wkjN#gl24).
* Previous history of unusual injury/illness e.g. unexplained apnoea (stopping breathing).
* Repeated attendance with injuries that may be due to [neglect](https://westmidlands.procedures.org.uk/page/glossary?term=Neglect&g=zcjN#gl7) or [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51).
* Consider child maltreatment if there is an unusual pattern of presentation to and contact with health care workers, or there are frequent presentations or reports of injuries (Child maltreatment: when to suspect maltreatment in under 18s. NICE)

**Bruising**

Bruising is the commonest presenting feature of physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) in children.  Reviews of the research conclude that bruising is strongly related to mobility and that bruising in a baby/child who is not yet crawling, and therefore has no independent mobility, is very unusual. While up to 60% of older children who are walking have bruising, it is found in <1% of not independently mobile infants. The younger the child the greater the risk that bruising is non-accidental and the greater potential risk to the child. Bruises are rare in infants and pre-cruisers.  Bruises in infants younger than 9 months and who are not yet beginning to ambulate should lead to consideration of [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) or illness as causative (Those who don’t cruise rarely bruise.  [Sugar, MD](https://jamanetwork.com/searchresults?author=Naomi+F.+Sugar&q=Naomi+F.+Sugar) et al)

Accidental bruising from everyday falls, trips and slips usually result in a single bruise on a bony prominence over the anterior surface of the body, the most common location being the shins and “facial-T” (forehead, bridge of nose, mouth and point of chin).  They may also occur over the occiput or lower back.  They are not patterned or petechial in nature.  Petechiae are tiny red or purple spots which often get misdiagnosed as a rash.

Inflicted bruises are more likely if:

* Infant is not yet independently mobile
* Multiple bruises, often in non-related sites, on the anterior (front) and posterior (back) surfaces of the body, though attributed to a single injury
* Patterned, showing a positive or negative image of an implement used (e.g hand slap mark)
* Petechial
* Located on protected areas such as the neck, cheek, ear, buttocks, abdomen, upper and mid back, genitalia, posterior thighs and forearms.

A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given.

Bruising in a child who is not independently mobile in any location is a concern.  It is recognised that a small percentage of bruising in non-independently mobile babies and children will have an innocent explanation (including medical causes). This practice guidance should be followed nevertheless because of the difficulty in excluding non-accidental injury.

**Fractures**

The majority of abused children with fractures are <18 months old; whereas most accidental fractures occur in children over 5 years.

All fractures require appropriate explanation and this must be consistent with the child’s developmental age.

A humeral fracture is more likely to be due to [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) than accidental injury in a child under 18 months of age.  All humeral fractures in a non-mobile child are suspicious if there is no clear history of an accident.  Spiral fractures of the humerus are uncommon and are strongly associated with physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51).

Femoral fractures in children who are not independently mobile are suspicious of [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51), regardless of type of fracture.

Skull fractures are reported after head injury from a fall from a height and are reported in equal frequency in accidental injury and physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) in infants under the age of 1. Skull fractures may be associated with an overlying scalp haematoma and/or underlying localized subdural haematoma.  There is some debate about the height threshold for which such injuries occur from a fall; recent studies indicate that such injuries only occur when falling from a height >60cm (Biomechanical characteristics of head injuries from falls in children younger than 18 months.  Hughes et al).

**Burns and scalds / thermal injuries**

Burns and scalds to children are common.  70% of accidental burns and scalds in   childhood occur in children under 3 years of age with the greatest prevalence being in toddlers between the ages of 12 and 24 months. An estimated 10% are secondary to maltreatment.

All childhood burns must be carefully assessed.  The burn may be as a result of [neglect](https://westmidlands.procedures.org.uk/page/glossary?term=Neglect&g=zcjN#gl7) or lack of supervision.

Scalds from physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) predominate in infants and toddlers:

* Frequently involve immersion injury and affect the hands and feet with clearly demarcated edges (glove and stocking appearance).
* Frequently involve the buttocks and legs.
* Frequently are bilateral and symmetrical
* Any soft tissue area not expected to come into contact with a hot object (e.g. back of hands, soles of feet, back, buttocks) in a child who is not yet independently mobile should automatically raise suspicion.

Abusive contact burns are generally found anywhere on the body.  The site often involves regions of the body that the child is unable to reach themselves.  They are often multiple or have a clear demarcation such as an iron burn, unlike accidental burns which are generally single (apart from iron burns).

Intentional cigarette burns are circular lesions ~0.5cm in diameter and are often multiple and located on the back of the hand.  They heal to leave circular scars.

Thermal injuries including cold injuries (swollen red hands or feet) with no obvious explanation may be a sign of child maltreatment.

**Bites**

Human bites are always inflicted injuries.  Human bites may be mistaken for bruises.  They may need specialist opinion to differentiate between an adult bite and a child’s bite.

Consider [neglect](https://westmidlands.procedures.org.uk/page/glossary?term=Neglect&g=zcjN#gl7) if an animal bite occurs in a child under the age of 2 years, and particularly in a child under 1 who is not independently mobilising.

**Other injuries**

Bruised lip or torn frenum (small piece of skin between the inside of the upper and lower lip and gum).  Any oral injury when an explanation is absent or unsuitable should raise concerns.

Subconjunctival haemorrhage (small bleeds into the whites of the eyes) are a frequent finding in otherwise healthy newborn babies.  They should resolve in 10-14 days but sometimes can take a bit longer.  They are also thought to occur in infants with prolonged coughing or blood disorders.  However 2 studies report their presence in child [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51).  NICE guidance suggests child maltreatment if a child has retinal haemorrhages or injury to the eye in the absence of major confirmed trauma or a known medical explanation.

Lacerations, abrasions and scars are not common in children under 1 year of age without a suitable explanation.

**Mongolian blue spots**

Mongolian blue spots are a type of blue / grey pigmented birthmark usually present at birth or soon after and are usually located on the buttocks or lower back and less commonly arms or trunk.

Mongolian blue spots and bruises do look very similar however bruises change colour, shape and size over the course of just a few days while Mongolian blue spots stay the same for many years.

Mongolian blue spots are not painful when touched.

Mongolian blue spots can be mistaken for bruises and should be recorded on a baby’s medical records from birth.

**All non-mobile infants and non-mobile children of any age with an injury should be managed in line with the procedures below.**

For more information, please refer to [Reference/Resources](http://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age#s4979).

|  |
| --- |
|  |

**Definitions/Scope of Guidance**

* **Not Independently Mobile**: A child of any age who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. It should be noted that this guidance applies to **all**babies under the age of six months. The guidance also applies to older immobile children, for example immobility due to disability/illness.
* **Bruising/Suspicious marks**: It is not always easy to identify with certainty a skin mark as a bruise. Practitioners should take action in line with this guidance if they believe that there is a possibility that the observed skin mark could be a bruise or could be the result of injury or trauma.
* **Mobile Children**: While accidental and innocent bruising is significantly more common in older mobile children, practitioners are reminded that mobile children who are abused may also present with bruising and suspicious injuries. If appropriate to the practitioner’s role, knowledge and skills they should seek a satisfactory explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history, to ensure that it is consistent with an innocent explanation. Otherwise the practitioner should seek supervision and guidance from expert practitioners/Children’s Services.

|  |
| --- |
|  |

**What to do if any type of injury (including bruises) are seen on a non-mobile child/baby or there are concerns about non-accidental injury in a child under 2 years**

**Children’s Health Care Practitioners – including General Practitioners, school nurses, health visitors, midwives**

* Should discuss the bruise / injury with the parent /carer and enquire into its explanation, origin, characteristics and Detailed documentation of this should be made in the child’s records.
* Should advise and explain to the parents/carers of the need to refer to Children’s Services and the need for a medical examination with the on call This will assess the likelihood of non-accidental versus accidental injury and to arrange any necessary investigations to exclude a medical condition. In particular, practitioners should explain at an early stage why, in cases of injuries in non-independently mobile babies and children, additional concern, questioning and examination are required. The decision to refer to Children's Services and for a medical examination should be explained to the parents or carers frankly and honestly.
* The responsibility for arranging the medical remains with Children’s Services. Children’s services may choose to escort the child to the venue for the medical examination and ask you to ensure the parents/ carers are not left alone with the baby/child until a social worker Should the parents/carers not wish to allow this, inform the parents of the advice you have received. Should they remain adamant that they wish to leave or will not allow you to stay with them, then inform them that you will have to the call police. **If you have concerns about the personal safety of yourself or other staff or in relation to the safety of the child or their siblings in these situations you should call the police immediately.**
* Should record all discussions, decisions and actions, and confirm your referral to Children’s Services in writing within 48hrs as per standard You may also choose to speak to the Paediatrician who will be doing the medical examination to explain your concerns and ensure they have all the relevant information.
* In the case of newborn infants where bruising may be the result of birth trauma or instrumental delivery, professionals should remain alert to the possibility of physical [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) even in a hospital In this situation clinicians should take into account the birth history, the degree and continuity of professional supervision and the timing and characteristics of the bruising before coming to any conclusion. It is particularly important that accurate details of any such bruising should be communicated to the infant’s general practitioner, health visitor and community midwife. Where practitioners are uncertain whether bruising is the result of birth injury they should refer immediately to the on call Paediatrician. If concerns remain a referral to Children’s Services should be made. Wherever possible, the decision to refer should be undertaken jointly with the on call Paediatrician, however this requirement should not prevent an individual professional referring to Children's Services any child with bruising who, in their judgement, may be at risk of child [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51). If a referral is not made, the reason must be documented in detail with the names of the professionals taking this decision.
* Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be referred immediately to Such a referral should not be delayed by a referral to Children’s Services; however it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children’s Services is made.

**Babies/Children presenting at Emergency Department (ED)**

* ED practitioners should follow their local hospital policy and procedures. If an injury is seen in a non-mobile child a discussion with Children’s Services should occur even if the injury is felt to be accidental to ensure that all available information is used to make that decision.  If a referral to Children’s Services is made, staff should be prepared to attend (or nominate a member of the team to attend if they are not on duty) a strategy meeting within 24 hours.
* If a referral is not made, the reason must be documented in detail with the names of the professionals taking this
* ED staff should use the information on previous ED attendances, the Child Protection Information System (CP-IS) and the completed Child Safeguarding Questionnaire on the ED record to assist in reaching a decision as whether to refer to Children’s Services.

**All other practitioners- including nursery staff, children centre workers, education, social workers, and other (non- child health) professionals**

* Should discuss the bruise / suspicious mark with the parent /carer and enquire into its explanation, origin, characteristics and Detailed documentation of this should be made in the child’s records.
* Should advise and explain to the parents/carers of the need to refer to Children’s services and the need for a medical examination with the on call This will assess the likelihood of non-accidental versus accidental injury and to arrange any necessary investigations to exclude a medical condition. In particular, practitioners should explain at an early stage why, in cases of injuries in non-independently mobile babies and children, additional concern, questioning and examination are required. The decision to refer to Children's Services and for a medical examination should be explained to the parents or carers frankly and honestly.
* The responsibility for arranging the medical remains with Children’s Services. Children’s Services may choose to escort the child to the venue of the medical examination and ask you to ensure the parents/ carers are not left alone with the baby/child until a social worker Should the parents/carers not wish to allow this inform the parents/carers of the advice you have received and if they are adamant they want to take the child from the setting / will not allow you to stay with them then inform them that you will have to the call police. **If you have concerns about the personal safety of yourself or other staff or in relation to the safety of the child in these situations you should call the police immediately.**
* Should make a telephone referral to Children’s Services, followed up with a written referral within 48 hours as per policy, using the Multi Agency Referral Form (Children’s services will provide the form if you do not have access to one).

|  |
| --- |
|  |

**Responsibility of Children’s Services**

When a referral is made under this guideline, Children’s Services should, as a minimum:

* Take and record full details of the case
* Check whether the child is known to Children’s Services.
* Decide, with the paediatrician, whether further action is needed and make arrangements for the medical examination (a social worker should attend the medical examination).
* Ensure that the adult who attends with the child has parental responsibility and can give consent.
* Decide whether a strategy meeting is required
* Give consideration to the  early  involvement  of  Police  in  order to consider investigative and evidential requirements as  bruising may have occurred as a result of assault/ill treatment
* Record the decision and notify the referrer, Health Visitor & GP
* Ensure the parents/carers remain informed as appropriate
* Inform the referrer and appropriate practitioners of next steps.

|  |
| --- |
|  |

**Responsibility of On call Paediatrician**

The assessment of the child should be carried out by a paediatrician with Level 3 competencies as per Safeguarding Children and Young People: Roles and Responsibilities for Healthcare Staff.  Where a trainee carries out the assessment, they should be supervised by a consultant or senior paediatrician. The on call Consultant Paediatrician should ensure that they or a nominated middle grade or specialty doctor, as a minimum:

* Take and record full details of the case
* Be part of the initial strategy discussion and decide together, with the Social worker, the arrangements for and management of the medical examination and whether further action is required
* Record the decision in the child’s notes
* [Medical assessments](https://westmidlands.procedures.org.uk/page/glossary?term=Medical+assessment&g=yEzN#gl46) should be recorded on the Child Protection Medical Proforma in accordance with policy in the majority of cases. If the child is admitted through the Emergency Department the paediatric admission booklet may be used with use of body maps to document injuries accurately.  Good practice guidelines should be followed as per the Child Protection Companion
* The Consultant Paediatrician holds ultimate responsibility for the case, regardless of whether a middle grade or specialty doctor performs some of the above actions

|  |
| --- |
|  |

**References/Resources**

* Chapter 9 Recognition of Physical [Abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51).  Child Protection Companion.  RCPCH online document accessed June 2019 (hyperlink not available)
* [CG 89 When to Suspect Child Maltreatment. National Institute for Health and Care Excellence July 2009, updated September 2017](https://www.nice.org.uk/guidance/cg89/chapter/1-Guidance)
* [Bruises on Children: Core Info leaflet.  Updated September 2018](https://learning.nspcc.org.uk/research-resources/pre-2013/bruises-children-core-info-leaflet/)
* [Bruises in Infants and Toddlers: Those Who Don't Cruise Rarely Bruise.  Puget Sound Paediatric Research Network.  Sugar NF, Taylor JA, Feldman KW.  Arch Pediatr Adolesc Med 1999;153(4):399-403](https://jamanetwork.com/journals/jamapediatrics/fullarticle/346535)
* [Biomechanical characteristics of head injuries from falls in children younger than 48 months.  Hughes J, Maguire S, Jones M, et al.  Archives of Disease in Childhood 2016;101:310-315](https://adc.bmj.com/content/101/4/310.long)
* [Safeguarding Children and Young People: Roles and Responsibilities for Healthcare Staff.  Intercollegiate Document.  Fourth Edition January 2019](https://www.rcn.org.uk/professional-development/publications/pub-007366)