GREENWICH Safeguarding Children PARTNERSHIP

Bruising Protocol: Management of bruises in non-mobile babies and disabled children

Contents

1. Summary

- It is rare for non-mobile babies to have injuries (up to 1% may be accidental). Whilst it is important to keep an open mind, remember that a bruise or injury may be a sign of a serious medical condition or abuse, and that other injuries may be hidden. It is important to be curious about how the injury occurred and what explanations were provided by the parent/s and carers, and to document these carefully.

- Be familiar with birth marks; details are given below, or, look at the NHS website https://www.nhs.uk/conditions/birthmarks/ which has a clear outline of the different marks that you may see. Birth marks may be documented in the red book, or the family may have a photograph.

- If in doubt talk to a supervisor as soon as possible on the same day

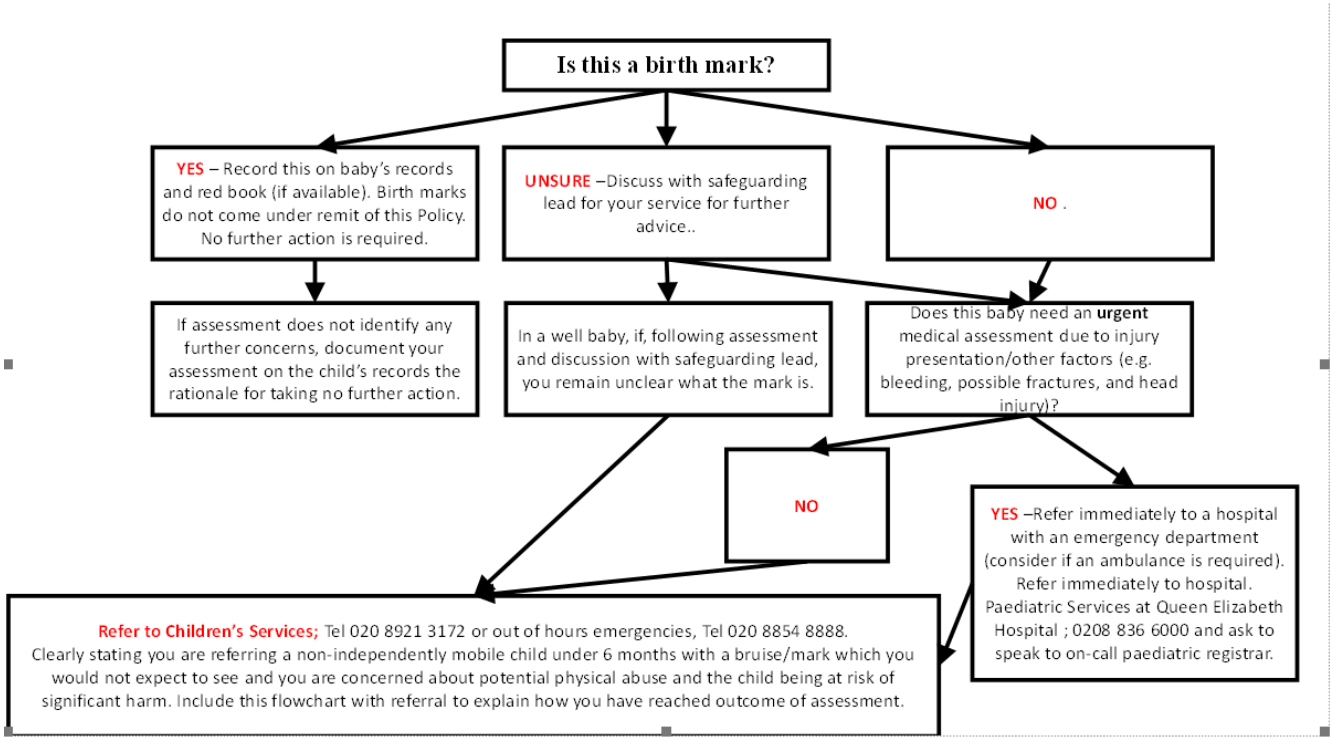
- It is not your place to judge if the bruise is in an 'accidental' group, but it is your role to be kind and explain that your guidance says that you need to discuss any bruise or new mark on a baby with your supervisor, and, that the baby almost always needs to be examined to ensure that they are well. It is a difficult time for parents, and they will need support, but, remember that your primary focus and concern is the child, and that you or your supervisor needs to refer to social care and not wait and see.

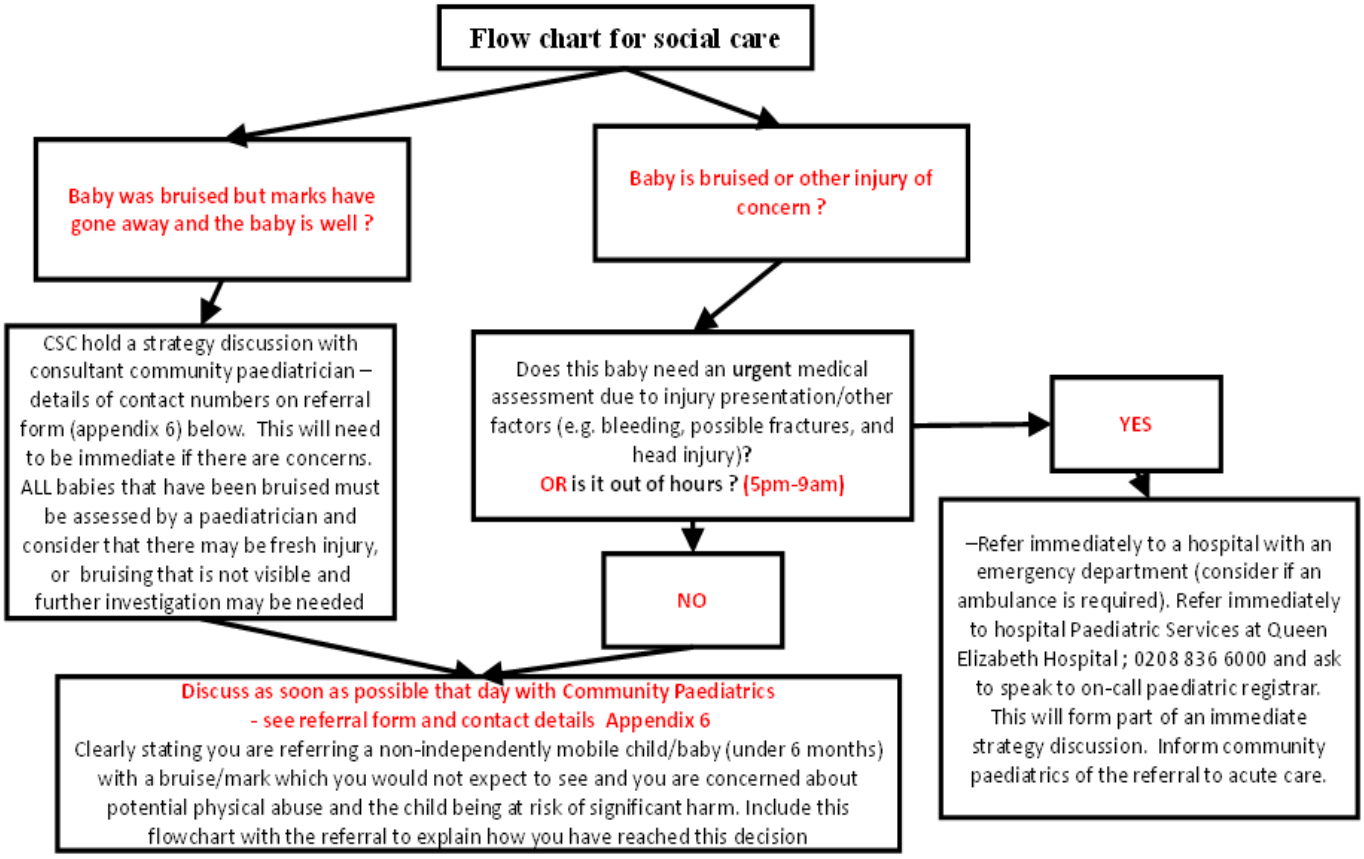
- If the baby is unwell, or bruising has just happened with no cause, then they will need to be seen at hospital urgently. You will need to explain that all babies are referred to Children's Social Care as part of the guidance if there are bruises, and that they will get the right help for their baby.

- If the carer does not agree to go to hospital or meet social care, then Police Protection may be needed, in urgent cases call 999 for a uniform police response, they will be able to assess and call a specialist child protection officer for advice if necessary. (Non-urgent cases are referred to the police through social services.)

- Following a referral to Children's Social Care, an allocated social worker will arrange a Multi-Agency Strategy Meeting, and Health will be invited to participate and share information and plan where to have the medical examination to determine the cause of bruising and any injuries. This should be on the same day in hospital if admitted or presenting outside of working hours, or, at Community Child Health.

Summary charts; GSCP bruising in pre-mobile babies 2021
For full details see the guidance below





2. Full Protocol

2.1 AIM

The aim of this guidance is to provide frontline, Health and Social Care staff with information to support the assessment, management and referral of infants / babies and also disabled children who are not independently mobile, and who present with injuries even if they appear to have resolved as *it is rare for non-mobile babies/children to have bruises*. It is important for you to seek advice if you are unsure.

2.2 INTRODUCTION

Bruising is the most common presenting feature of physical abuse in children. National and Local Serious Case Reviews (SCIE, 2015) and child safeguarding practice reviews highlight that frontline staff sometimes underestimate or ignore the possibility that abuse is the most likely cause of bruising in babies /children who are not independently mobile (i.e., those not yet crawling, cruising or walking independently, or children with a disability such that they are not mobile).

National Institute for Health and Clinical Excellence guidance (2013) states that bruising in any child who is not independently mobile should prompt suspicion of maltreatment as these babies/children are the least likely to sustain accidental bruises.

N.B Always remember: Infants who don't cruise, don't bruise.

Whilst professional judgement and responsibility is recognised as important, we should always refer if there has been an injury. Therefore, a referral to Royal Borough of Greenwich Children Services is needed, as they will need to arrange for a discussion with the paediatrician and for the baby/pre-mobile child to be examined by an appropriate Paediatrician for a child protection medical on all babies who are under 6 months who have suspicious bruises or marks, and the social worker will need to liaise with the hospital for any child already admitted with concerning injuries.

Some marks seen on babies /infants are normal, such as: confirmed birth injury; Blue Spot and other marks;(Appendix 1). These may be present from birth or develop after birth. Assessment of all marks should be undertaken using the Assessment Tool (Appendices 2-3). You should always record the presence of all visible marks in your agency records and the Parent Held Record (Red book) if available.

Some marks may rarely be the sign of serious underlying health conditions needing urgent hospital assessment, but any suspicion about injuries should lead to a referral to children's social care.

If in any doubt, discuss with their safeguarding lead or ring Children's Social Care to discuss further.

Bruising and swelling can emerge or change over time, and it is important to document exactly what you see. It is not possible to age bruises accurately. Bruises look different on different skin types and are easy to miss in poor light.

2.3 GUIDANCE TARGET AUDIENCE

This protocol is for all staff who have contact children and their families, 'Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.' (Working together, 2018).

2.4 CHILDREN WITH A DISABILITY

Consideration should be given to applying this guidance to older children who are not independently mobile by reason of a disability.

2.5 DIVERSITY FACTORS

Consideration should be given to cultural needs of children and their families and carers, however, cultural practices that are abusive are never an acceptable reason for child maltreatment.

All frontline staff should be aware of, and sensitive to, any difficulties in communicating this guidance to parents/ carers and children. There may be learning difficulty / disability, a language barrier or poor understanding of legislation in the UK. It is important that the baby/pre-mobile child is seen as swiftly as possible and assessment may indicate that additional support and provision is needed to assist effective communication, but this should not hinder immediate referral.

2.6 PRESENTATION AND ASSESSMENT

Clearly, if the baby is unwell, immediate referral to the hospital may be needed (see flowchart below, Appendix 3 & 5)

Regarding bruising, research has shown that even a small bruise on a pre-mobile baby can be a sign of abuse as they are much less likely to bruise than mobile infants.

You should make a referral to Children's Services following the identification of **any** suspicious bruise or mark on any baby or child. You should be familiar with whether it is more likely to be a birth mark, and if in doubt ask for advice. As a caution, several of us have seen chocolate on the face of a young child, or, witnessed a parent saying it is too cold to undress the baby for weighing, *just to cover up bruising*.

The practitioner who identifies the suspicious bruise or mark should undertake an assessment. This assessment must firstly take into account if the mark is suspicious or consider if it is a normal birth mark using the Assessment Tool *(Appendices 1-3).* The completed document should be attached to any referral made to Children's Services and ideally include a completed body map of readily visible marks (please note that a detailed examination would be undertaken by the paediatrician). The referral must also state exactly what they were told by the carer as to how the mark happened.

Following receipt of this referral, Children's Services should consider the information contained in the referral and consider convening a Strategy discussion /meeting that should discuss the most appropriate place for the baby to be assessed and would usually lead to the referral for a Child protection Medical *(Appendices 5-7)*. All children with bruises or a history of bruises MUST be seen by a paediatrician even if the bruise has faded. Remember that bruises fade but the baby should be seen as soon as possible by the paediatrician.

The Child Protection Medical must be undertaken by a trained Paediatrician, therefore referrals where abuse is suspected should *not* be made to a GP or other primary care provider under this Guidance.

If the baby/child needs immediate medical attention, then they should be referred directly to the Emergency Department in addition to referring to children's social care.

Social care will request a child protection medical by referral to the community paediatrician as part of an urgent strategy discussion, or the hospital paediatrician if the child was first admitted to hospital or still in the emergency department, or if they have discharged them prior to the child protection medical *(Appendix 5 for flow chart)*.

The practitioner should ensure that the rationale for their decision is documented in their agency records along with the names of who has contributed to the decision-making process.

2.7 BACKGROUND FACTORS

When making an assessment and referral to social care you should always review the information you hold within your agency with regards to the family/carer and child, to identify all relevant risk factors including parental and child risk factors.

You should pay particular attention to any history of domestic abuse, poor parental health, mental health (including perinatal mental health), learning difficulty/disability, drug or alcohol misuse, previous known social care or criminal history, poor attachment or previous inconclusive investigations of injury or bruises to any child.

A history of poor engagement with health services/ advice in relation to the needs/care of the baby, including any missed appointments such as missed baby checks, immunisations or hospital appointments, or not following advice such as for safe sleeping, are also of concern.

This list is not exhaustive, and you should always consider sharing in detail, all relevant information known to your agency.

Whenever possible, the child's parent or carer should be informed before sharing confidential information. However, if this would incur delay, or if to do so would put the child or the professional at risk, then practitioners can be reassured that confidential information may be lawfully shared if it can be justified in the public interest (Information Sharing: Guidance for Practitioners and Managers HM Government 2008). 'The public interest' includes the belief that a child may be suffering, or be at risk of suffering, significant harm (Working Together to Safeguard Children 2018).

Where there are no documented or known risk factors your referral should state that 'from review of your agency records there are *no known* risk factors for parents /carer or child'. It would be misleading to just state that there are no concerns. It should also state any need for communication support, and who has parental responsibility.

2.8 EMERGENCY MEDICAL CONDITIONS OR INJURIES

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 the hospital Emergency Department.* Occasionally spontaneous bruising may occur as a result of medication,

or some serious medical conditions and these children should be seen in hospital. Child protection issues should not delay the referral of a seriously ill child to acute paediatric services but may need to continue in parallel. Foster carers or child minders need to understand the need to refer a bruised baby/non-mobile child to Children's Social Care and to recognise signs of illness and refer to hospital urgently if needed.

It is the responsibility of the practitioner dealing with the child to ensure that, where appropriate, a referral to Children's Social Care has been made. It should be noted that children may be abused with serious injuries (including sustaining fractures, serious head injuries and intra-abdominal injuries) but have no apparent bruising or external injury. A referral to hospital under the above circumstance should not be delayed by a referral to Children's Social Care, which, if necessary, should be undertaken within the hospital.

2.9 REFERRAL TO CHILDREN'S SERVICES

Once the practitioner identifying the suspicious bruise or mark has undertaken an assessment using the Assessment tool (*Appendices 1-3)*, and this indicates a referral to Children Services, (any urgent referral to the hospital would have been made immediately), then the practitioner should undertake the following in order to refer to social care *(Appendix 4)* as soon as possible:

- Ensure sufficient information is included in any referral to assist Children's Services in responding. This would include basic details such as name, date of birth, address and contact details for all adults and children
- Ensure all other relevant information about the baby/child and any other children and adults associated with this child is collated from their agency records (see section 6 Risk Factors). **Remember, a clear factual safeguarding referral results in pro-active responses from Children's services, and better outcomes for children.**
- Ensure all details are included on the referral with evidence that is factual and descriptive and include an analysis of concerns.
- Ensure any other documents are available to Children's Services which includes a completed Assessment Tool and body map *(Appendix 6 and 7)*
- Ensure you immediately follow up a verbal referral in writing.
- Ensure the main parent / carer is made aware of the referral (and this is best practice where it is safe to do so *unless* other issues are suspected such a FII or CSA) however consent to make a referral is not an absolute requirement as you are referring in the best interest of the child.
- Give the carer/ parent information about physical abuse and how to access emotional or other support.

Consider Domestic Violence in the home, and other risk factors for abuse, and identify support for the carer.

Once a referral has been made, Children's Services will respond and arrange a strategy discussion with police, children's social care and health.
Parents / Carers should always be informed about the process in order to decrease anxiety (unless there are contraindications as noted above). On the rare occasion that there are any significant concerns around unwanted parental behaviours an immediate risk assessment of the situation should be undertaken. **Where there are immediate concerns for safety of the child or practitioner the Police should be contacted on 999.**

2.10 INVOLVEMENT OF PARENTS

Explanation of the referral process should always be carried out sensitively and in a private place if at all possible, to avoid further distress to parents / carers. It is important to document your observations and parental explanations word for word. If it is appropriate to do so (unless concern about increased risk such as FII, sexual abuse) it is important that professionals explain to parents/ carers, in a frank and honest way, why additional assessment is required. The decision to refer to Children's Services must be explained along with the referral process for medical.

If parents/ carers refuse to co-operate or refuse to take their child, or to be available for further assessment, this should be reported immediately to Children's Services and to the Police (999) if there are immediate concerns for the child or staff safety. In these cases, if at all possible, the child should be kept under supervision until steps can be taken to secure his or her safety. Professionals should also consider their own safety at this time.

If you have serious concern about the safety of the child and they are taken away by a potential abuser, then you may first need to phone the police (999) to request to request police assistance in using their powers such as Police Protection.

2.11 POLICE RESPONSE

2.11.1 The Police on receipt of a referral (or call to 101/999) for an injured baby will carry out an assessment and refer to children's social care even if the bruising seems trivial, and if necessary, also ensure that the child /baby is taken to hospital if they are unwell.

2.11.2 They will carry out usual procedures and observations, and consider the need for any immediate safeguarding measures to be implemented to safeguarding any other child in the household as well as contribute to the strategy discussion.

2.11.3 If this has been referred to the police from social services then specialist child protection (CAIT) officers may attend, however if it is out of hours (i.e., during the night and at weekends) it may be uniform officers from emergency response attending initially before special officers are notified.

2.12 CHILDREN'S SERVICES RESPONSE

2.12.1 Children's Services should take any referral of a baby with **suspicious marks** as *requiring a medical and further multi agency investigation*.

2.12.2 Referral for a strategy discussion should be an immediate response, as a CP or other medical is always needed if a baby is bruised and should include the paediatrician in order to arrange the medical as soon as possible. There may need to be a further multiagency strategy meeting which should involve as a minimum Children's Social Care, Health and Police, and the referrer where appropriate.

2.12.3 The paediatrician should consider the medical needs of the baby/child and whether a hospital medical assessment is required. The baby/child should also be assessed for signs or maltreatment, and any medical condition. This should be done at the earliest opportunity by the most appropriate medical professional.

2.12.4 If the baby/child already has a Social Worker, Children's Services should ensure that the named social worker or a duty Social Worker responds immediately to the referrer and to arrange the medical and strategy discussion with the paediatrician *(Appendix 6-7)*.

2.12.5 A bruised baby will always need to be seen, and this may indicate a serious underlying condition or abuse, and it is essential to discuss with the community paediatrician immediately, or with the hospital on call paediatrician out of hours.

2.13 Out of Hours Children's Social Care response

If the matter arises out of hours and was referred in the first instance to social care the Out of Hours team should not delay in making a referral to hospital and make sure that the baby is safe. The Out of Hours Social Worker (phone number 020 8854 8888) should contact the referrer if necessary, for more information as required. If a Strategy Meeting is required, the Out of Hours team will make contact with the Police and the Out of Hours Paediatric Services for the discussion to occur.
Paediatric Services: Queen Elizabeth Hospital on 0208 836 6000 and ask to speak to on-call paediatric registrar.

2.14 The Child Protection Medical and Children's Social Care

(See appendices 5 - 7)

The social worker should arrange to accompany the baby and parents to the Child Protection Medical Assessment and should give information to the carers about the medical, that the baby will be seen by a doctor to make sure that the baby/child is well and safe, and that they will need to ask about child and family information in order to help their assessment.

If there is any delay and concern about the child particularly if the child cannot be seen before 5pm the same day, they should be seen in the acute setting after discussion with the on-call community paediatrician.

To reiterate, referral must not be delayed as signs of abuse fade quickly. Completion of the referral form should not take the place of a strategy discussion. *The child should still be seen whether or not the bruises have faded or disappeared.* It is essential for social care to arrange for someone with parental responsibility to attend the medical, or is available to give consent remotely. Written consent is not sufficient.

2.15 PAEDIATRICIAN RESPONSE

A strategy discussion with the community paediatrician should precede the arrangement for the child protection medical.

This medical must always be undertaken by an appropriately trained Paediatrician and usually in community paediatrics. If the child is likely to arrive out of hours, then advice should be given by the community paediatrician about how to obtain the medical at the hospital, in order to document injuries and ensure a place of safety for a child.

At the medical consent should be obtained from the parent/carer with parental responsibility and the assessment should be explained verbally to the parent/carer with parental responsibility and an information leaflet given if available.

This is a holistic assessment. A full history from the parent/carer should be taken with quote marks around important descriptions of the mechanism of injury. Any commentary by the carer should also be documented as part of the history. A detailed health and developmental history should be taken, including attendance at appointments. The examination is full and includes observations of development.

Body charts must be completed carefully with measurements and annotation. The assessment should include a detailed description of the findings including signs of neglect and the voice of the child (including irritability, response to handling or examination of the injury).

The report should outline what the doctor is concerned about and be structured so that it is easy for another professional to follow and not assume that the reader is familiar with medical language. It is important to state that bruising in a pre-mobile child is unlikely to be accidental (unless a medical condition), and note the patterns of injury if indicative of abuse. Important unknowns should be noted; for example, whether any other risk factors or background are known or not known to the doctor, as in general, a normal examination does not mean that the child is safe. There should be a clear action plan, including any further investigations that are needed.

Following the Child Protection Medical, the Paediatrician who examines the baby/child should liaise verbally with the Social Worker with regards to the outcome of the assessment including findings and concerns, and the proposed plan. This should be followed up with a peer or supervisor reviewed written report within 5 working days and any changes to the advice or recommendations should be communicated immediately with the social worker. RCPCPH and local guidance for carrying out other investigations including skeletal survey should be followed.

Photography should be carried out by formal referral to Medical Photography by the examining paediatrician, and should include measurements, and, parents should be made aware that it will include a picture of the face of the child for identification purposes, and that this will not be visible to any external assessor unless requested by the court. Referral for Medical Photography needs a signed consent from parent/carer with parental responsibility.

2.16 CROSS BORDER CHILDREN

Babies/children who are ordinarily resident in Greenwich or using Greenwich services would come under the remit of this guidance in terms of identifying potential harm, and referral to Greenwich social care.

Initial enquiries and investigations will be conducted by Greenwich Social Care with Police and Health partners along with liaison with the Local Authority in which the child is resident.

2.17 ESCALATION PROCESS

If you are concerned about the lack of agency response to a safeguarding concern, or of there is professional dispute across agencies you must discuss it with your safeguarding lead who will escalate it, as appropriate, according to the GSCP escalation policy.

3. References and Appendices

HM Government (2018) Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

HM Government (2018) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the safety of children. www.workingtogetheronline.co.uk

Maguire S (2010). **Which injuries may indicate child abuse?** *Arch Dis Child Educ Prac*t Ed 2010; 95: 170-77 http://www.ncbi.nlm.nih.gov/pubmed/20926622

National Institute for Health and Clinical Excellence. (July 2009 Last Modified March 2013) *When to suspect child maltreatment*. NICE clinical guideline 89. London https://www.nice.org.uk/guidance/cg89/chapter/1-Guidance

NHS Conditions Birthmarks https://www.nhs.uk/conditions/birthmarks/ accessed 2021/03/18

NSPCC (2009) *Core Info; Head and spinal injuries in children*. Cardiff University http://www.nspcc.org.uk/services-and-resources/research-and-resources/head-spinal-injuries-core-info/

NSPCC (2008) *Core Info; Thermal injuries on children.* Cardiff University http://www.nspcc.org.uk/services-and-resources/research-and-resources/thermal-injuries-core-info/

NSPCC (2007) *Core Info: Bruises on children.* Cardiff University http://www.nspcc.org.uk/services-and-resources/research-and-resources/bruises-children-core-info/

RCPCH Child Protection Evidence- Bruising https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising accessed 2021/03/18

SCIE (2015) Learning from Serious Case Reviews (03) Not making a referral after bruising to non-mobile babies – SCIE

4. Protocol Contributors and Authors

Dr Adjoa Ezekwe – Lead Consultant Community Paediatrician, Greenwich Community Paediatrics
Dr Grace Pereira – Designated Doctor for Child Death, Greenwich CCG
Dr Modupe Akindele – Named Doctor for Safeguarding Children, Greenwich Community Paediatrics
Dr Olutoyin Banjoko – Named Doctor for Safeguarding Children Lewisham and Greenwich NHS Trust
Teresa Doherty – Head of Quality Improvement Service & Quality Improvement Lead, RBG
Nicky Pace – Independent Scrutineer Greenwich Safeguarding Children's Partnership
Graham Hillsdon – Detective Sergeant Greenwich CAIT
Karen Scholz - Service Leader Safeguarding A (MASH, A&S Teams and Children's Out of Hours)
Zafer Yilkan – Head of Safeguarding, RBG Children's Services

Acknowledgement: Cambridge, Hertfordshire and Greenwich protocols

Protocol Authors:	Anita Erharbor	Dr Ann Lorek
Email:	anitaerhabor@nhs.net	ann.lorek@nhs.net
Reporting to:	Neil Kennett-Brown	
Email:	neil.kennett-brown@nhs.net	

5. APPENDIX 1

Congenital dermal melanocytosis (Mongolian Blue Spots)

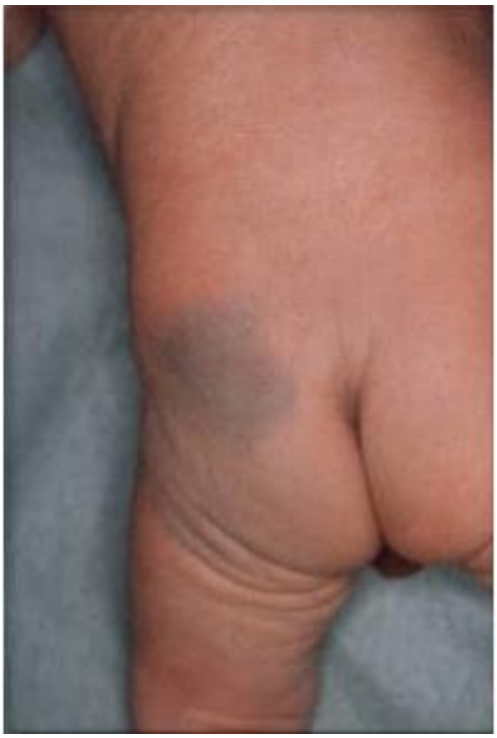
These birthmarks can sometimes be mistaken for bruises and raise questions about child abuse. Mongolian blue spots also known as congenital dermal melanocytosis are flat bluish or bluish-grey skin markings that commonly appear on babies at birth or shortly thereafter.

They are particularly common among darker-skinned children, such as Asian, African and those from mixed race parentage. The spots appear as dark blue lesions with unclear borders and irregular shapes. They can normally be found at the base of the spine, on the buttocks and back but they have been known to appear on other areas of the body such as the face, arms and shoulders.

Occasionally, Mongolian blue spots are mistaken for bruises and questions about child abuse arise. It is important to recognise that Mongolian blue spots are birthmarks, NOT bruises. For this reason, it is clearly important to document the presence of these spots on the area of the body in the Child Health record (Red Book).

Most health workers are now aware of the markings and questions of child abuse should not arise. When there is a dilemma in the diagnosis of the marks, please discuss with the GP if on site to verify and confirm the diagnosis, but otherwise follow the guidance and appendices below (2 – 5).

No testing is necessary. If the GP is unsure, he/she should contact the Paediatric team accordingly, but refer to social care according to this policy if there is any doubt that these may be bruises.



6. Appendix 2

Assessment of Marks in Babies under 6 months

Does the mark blanch on pressure? If the mark blanches on pressure, this is not a bruise but could be a birth mark. **How long has the mark been there for?** If mark present since birth or early life and persists – This is probably a birth mark. Ask parents to take a picture and review in 2-3 days and or ask a colleague to review with you as well **Does family have a history of birth marks?** Blue spots are rare in children of white European background, but very common in children of African, Middle Eastern, Mediterranean or Asian background. It is likely they are inherited.

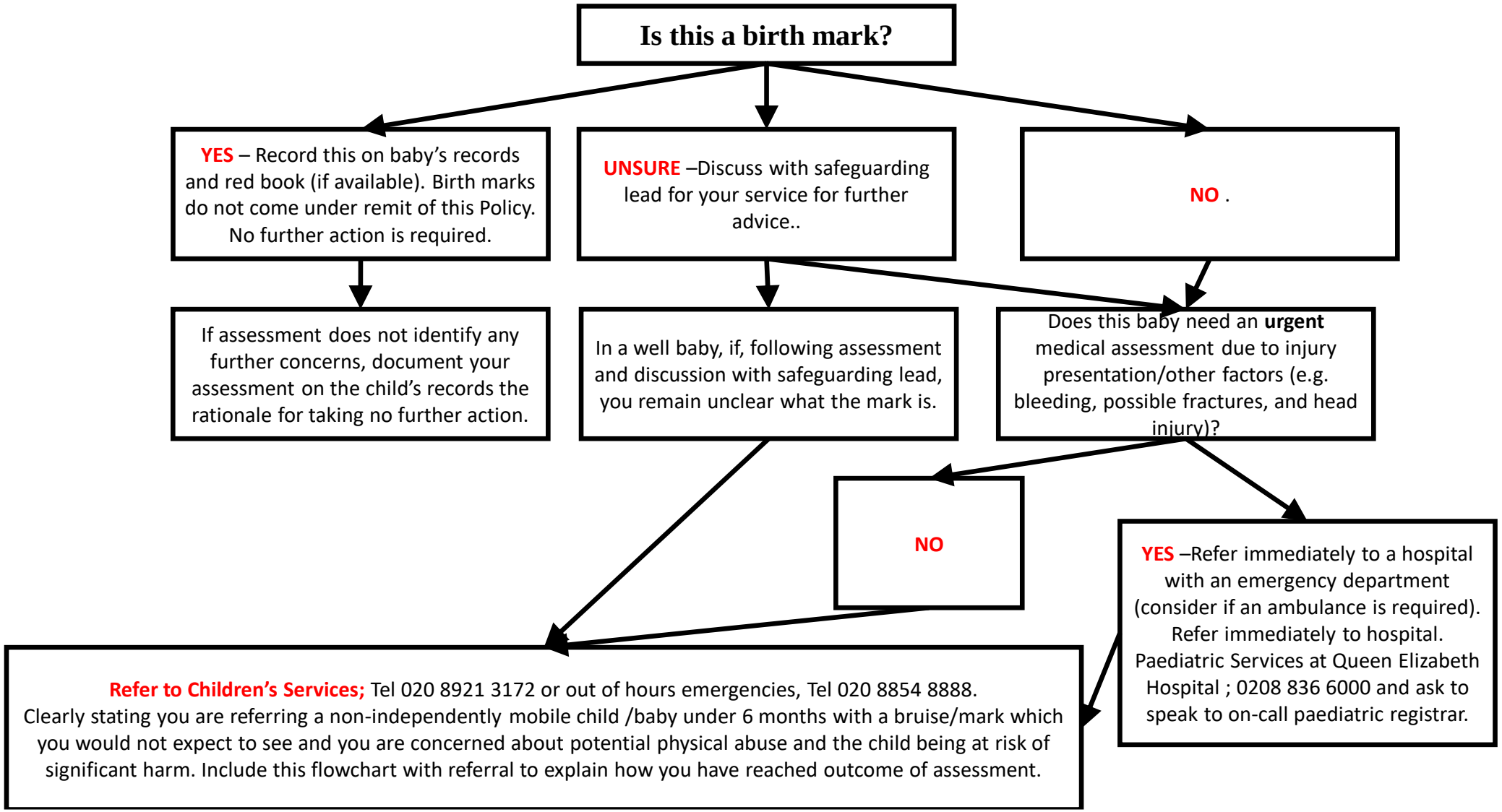
Blue Spot	Bruise
Blue spots are a type of birthmark that are present at birth or appear soon afterwards, either single or multiple in number. They are flat, blue-grey in colour and can vary from a very dark blue to a lighter grey. The colour is usually the same over the whole birthmark, with no lighter or darker areas as is sometimes seen in brown birthmarks	Doesn't blanch on pressure
Is not painful to touch	Can be painful to touch
Present from birth or early life and persists – can take years to fade	Bruises change colour and shape over a period of days
An irregular shape, with poorly distinguished edges	In most cases of inflicted "precursor" bruise, parents usually concede mark is a bruise, but the explanation suggests unreasonable force, e.g., held while feeding, or is implausible, e.g., lying on dummy, rattle did it.
Blue spots are can vary in size, but most are a few centimetres across. They can appear anywhere on the body, but are most common at the base of the spine, the buttocks or on the lower back. Occasionally they are present on the back of the shoulder.	Bruises can be any shape or size but may take the shape of an implement or force. There may be one or many bruises on any different part of the body.

- Consider how well the baby is with handling. Are there any other signs of pain and or discomfort or injury?
- If yes, review and risk assess as necessary. If unsure discuss with a supervisor and consider referral for a medical assessment – e.g., if the marks have newly appeared and could be a sign of septicaemia.
- If appropriate to role, examine the baby all over for any other marks/bruises
- If available, ask a colleague to view mark.

Action from assessment

- If you are considering this is a birth mark in a well baby– seek further advice from safeguarding lead for further support. Ask family to take a picture if able to (can be on mobile); professionals must not take a picture using their phone or camera device.
- Review the baby and mark in 2-3 days' time – if no change, this is likely to be a birth mark. If change is seen or the mark has disappeared – discuss with safeguarding advisor in service. Consider if referral is needed to Children's Services for further assessment of concern
- If following assessment and discussion with your safeguarding advisor, you remain unclear if this is a bruise or a birthmark, then you must refer to Children's Services as per flow chart.

7. Appendix 3 (PowerPoint version) - Assessment of Marks in Babies under 6 months



8. Appendix 4

REFERRALS TO CHILDREN'S SOCIAL CARE

For any referral for a baby that is bruised please note the following:
You should telephone all referrals in the first instance and follow this up immediately in writing using the inter-agency referral form
Tel 020 8921 3172 or out of hours emergencies, Tel 020 8854 8888.

Informing Parents/ Carers

- If parents are present, advise them of your concerns and give information about the medical
- On the rare occasions that a parent/carer is not present **do not contact parents** but refer immediately to Children Services and ascertain the action plan first before you inform parents

What information do I need before I refer?

- Ensure you have made a thorough assessment of the current information and the historical information held by your agency for all children and adults in the family
- Ensure you have a clear analysis of your concerns before you refer.
- Ensure you have the complete details of all children and parents/carers before you make this referral as you will be asked for these by the Customer Service Centre who need to follow their guidance to ensure your referral goes to the right department in Children's Services.

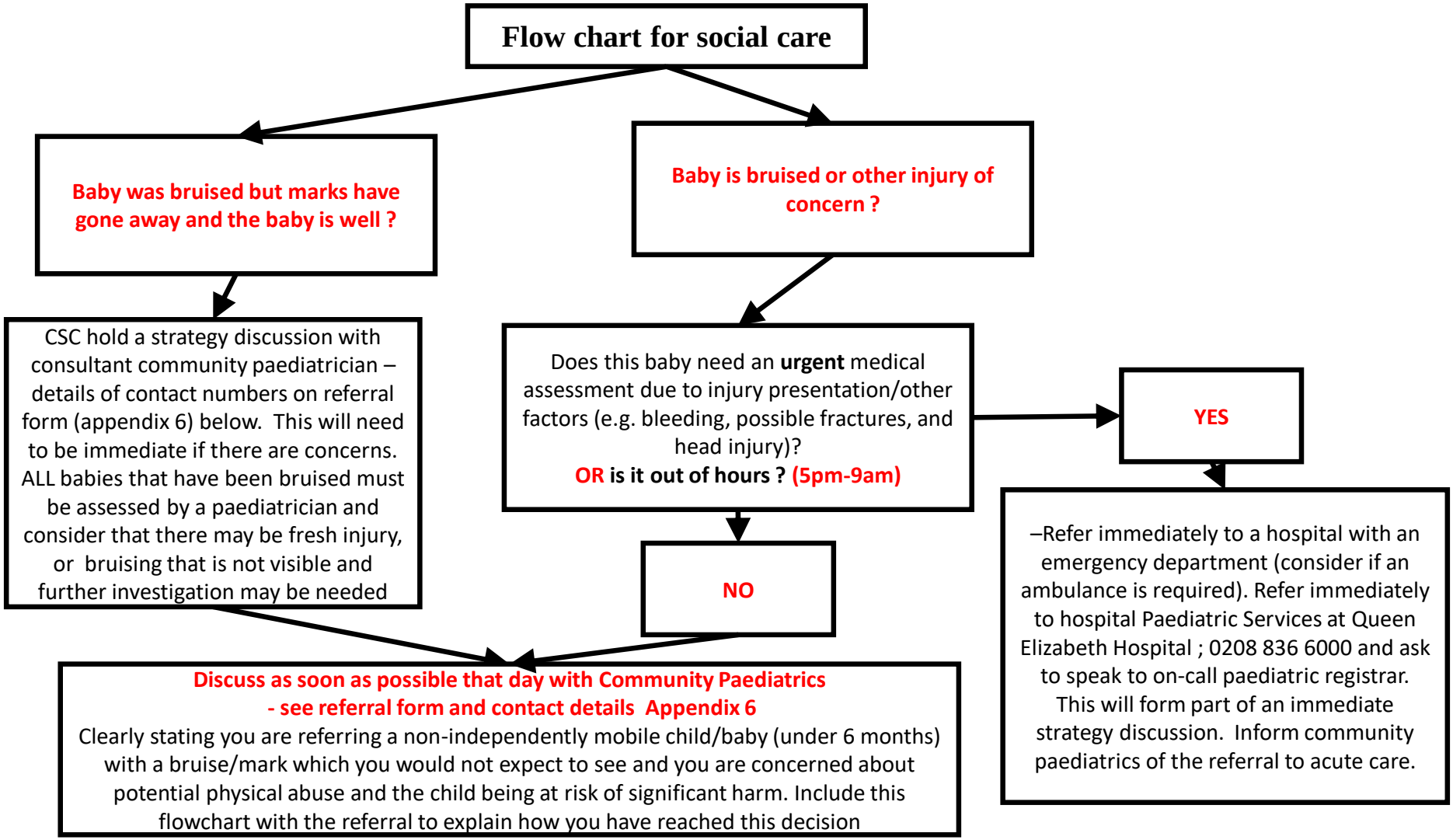
Contacting MASH?

- Clearly state your concerns and advise MASH professional that this is a referral due to suspicious mark / Bruise on a non-mobile child.
- Ensure you use this terminology and also to state that you are concerned that the child may be at risk of significant harm due to physical abuse. This will ensure the

referral is sent to children services for further investigation and referral for medical assessment

- Be aware that parents /cares may find this referral distressing. Ensure you explain to the parents you are making a referral to Children's Services unless a risk in doing so.
- Be very clear if there are additional risk factors from your records for any child or adult in the family and state clearly what these are.
- If there are no other risk factors you should state this however you should maintain you are concerned about significant risk of harm to the baby/child due to the bruise/mark on a non-mobile baby/child.
- Give your work contact details and availability.
- Ensure you take the **full** names, contact details and time of the calls for the people you speak to.
- Check correct information transfer by asking call centre staff member to repeat back what you have said.
- State that your expectation is that a SW from the referral and Assessment team will call you back as soon as possible
- Advise your Safeguarding lead of your actions.
- Always follow up your referral immediately in writing and securely send the email with any attachments (Assessment Tool and Body Map).
- Ensure the referral form is completed **in full**.
- Email your referral using the specified routes

9. Appendix 5


Flow chart for social care
Baby was bruised but marks have gone away and the baby is well ?
Baby is bruised or other injury of concern ?
CSC hold a strategy discussion with consultant community paediatrician – details of contact numbers on referral form (appendix 6) below. This will need to be immediate if there are concerns. ALL babies that have been bruised must be assessed by a paediatrician and consider that there may be fresh injury, or bruising that is not visible and further investigation may be needed
Does this baby need an urgent medical assessment due to injury presentation/other factors (e.g. bleeding, possible fractures, and head injury)?
OR is it out of hours ? (5pm-9am)
YES
NO
–Refer immediately to a hospital with an emergency department (consider if an ambulance is required). Refer immediately to hospital Paediatric Services at Queen Elizabeth Hospital ; 0208 836 6000 and ask to speak to on-call paediatric registrar. This will form part of an immediate strategy discussion. Inform community paediatrics of the referral to acute care.
Discuss as soon as possible that day with Community Paediatrics
- see referral form and contact details Appendix 6
Clearly stating you are referring a non-independently mobile child/baby (under 6 months) with a bruise/mark which you would not expect to see and you are concerned about potential physical abuse and the child being at risk of significant harm. Include this flowchart with the referral to explain how you have reached this decision

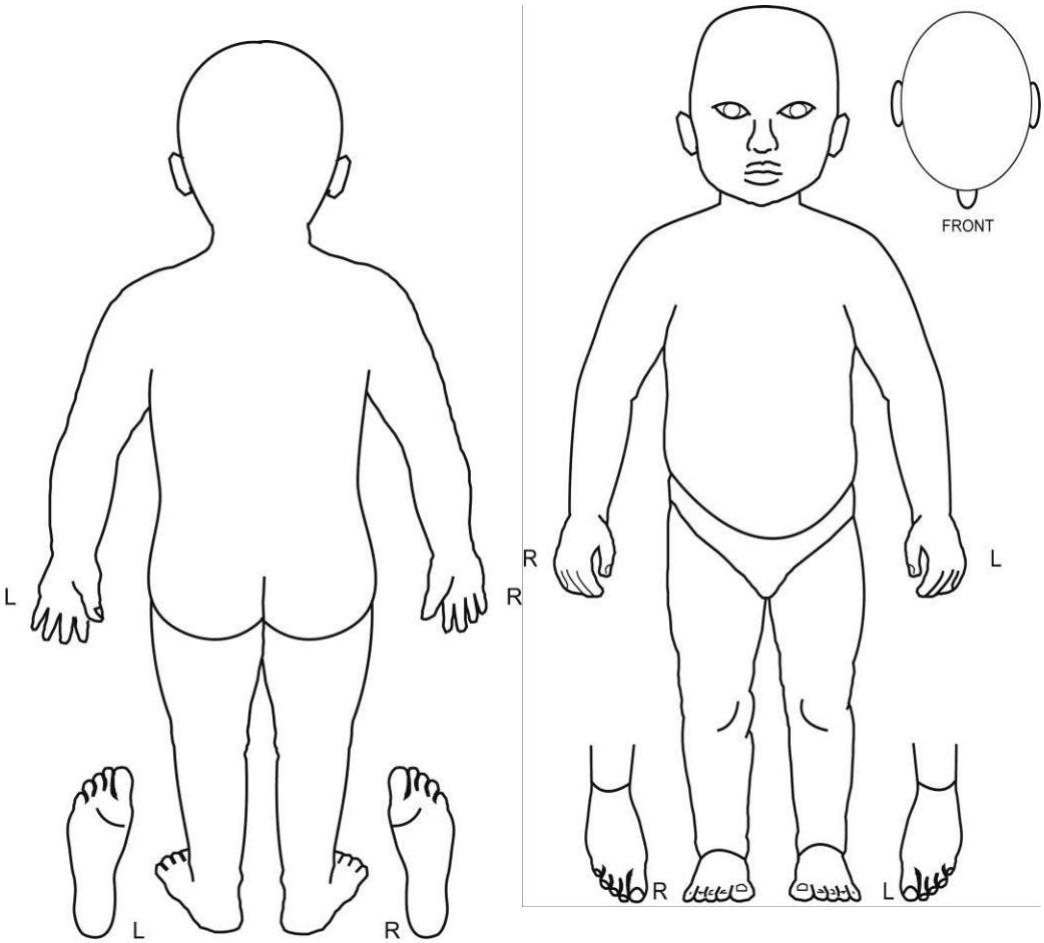
10. Appendix 6

Date: **Time:**

<u>Body Map Appendix 6 for visible injuries</u>

Child's name:

Date of birth:
Date/time of skin markings/injuries observed:
Who injuries observed by:
Information recorded:
Name: **Signature:**



11. Appendix 7

Oxleas NHS
NHS Foundation Trust

STRICTLY PRIVATE AND CONFIDENTIAL

CHILD PROTECTION MEDICAL REQUEST FORM FROM CHILDREN'S SOCIAL CARE

(Please read Guidance notes on last page)

Social Worker requesting medical:	
Social Worker attending with the child:	
Date of Request:	**Time of request:**
Office No:	**Mobile No:**
Email:	

Child's details (THIS FORM IS FOR ONE CHILD ONLY, PLEASE COMPLETE SEPARATE FORMS FOR SIBLINGS AND CROSS REFERENCE).	
Name:	**DOB:**
Male/Female:	**NHS NO:**
Ethnicity:	**GP:**
Home Address:	
Current Address (if different from above):	

CONSENT **Has consent been obtained from a person with parental responsibility?**		***Yes/No**
Who has Parental Responsibility?	☐ **Mother** ☐ **Father** ☐ **Local Authority** ☐ **Other** _____	
Will person with Parental Responsibility be attending? **(If No please provide a phone number so verbal consent for the medical can be obtained before the medical)**		***Yes/No**
Has the child had an ABE?		***Yes/No**
Is the family previously known to Social Care?		***Yes/No**
Is the child a Looked After Child?		***Yes/No**
Interpreter required? (to be booked <u>by Social Care</u> if required)		***Yes/No** ***Delete as applicable**

<u>REASON FOR MEDICAL</u>
Date of Incident:

Give details of the incident, injury, background etc. (*when you get to the end of the box…continue in the box on the next page*):

REASON FOR MEDICAL (Continued from previous page).

12. Practice Guidelines for Child Protection Examinations for Social Workers

- Complete the referral form electronically and send via email to oxl-tr.greenwichcommunitypaediatrics@nhs.net (secure e-mail address). Following this, you **MUST ALSO** telephone the child protection medical administrator on 07843 641844 or via the single point of access on 020 8836 8621 option 2 to ensure we have received and are aware of the request.

- The Social Worker should contact the 'Consultant of the Week' on 07500 606378 or 020 8836 8621 option 2 to discuss the case. This is usually after they have liaised with the police and assessed the child and spoken to the parents. This strategy discussion precedes the arrangement for a child protection medical and will be documented in the child's records.

- The Social Worker attending the medical will be expected to provide detailed information about the case and full history of the children and family.

- Social Workers should ensure children are accompanied by someone with parental responsibility; so that they can provide written consent to the doctor who will explain the process of the medical to them. Alternatively, if the parent is unable to attend, the social worker should attend with a current telephone number, so that the doctor can obtain verbal consent for the CP medical assessment.

- Please ensure the parent/carer accompanying the child is aware that the medical assessment can take up to two hours, or more, if there is more than one child being assessed.

- Children must be supervised at **ALL TIMES**. If there is more than one child attending, it is the responsibility of the Social Worker to make arrangements for the children to be appropriately supervised during the time they are attend for the medical assessment.

- Please advise the parent/carer accompanying the child to bring a drink, a snack and a favourite toy. If this is a baby, then bring nappies, bottles of milk, comforters etc., as these are not supplied during the medical.

- Social Workers should ensure that arrangements are made for any other children in the family can be collected from school/nursery if necessary.

- **Social workers and families will need to arrive promptly.** Doctors are usually running tight schedules and delays can impact on other work and mean that clinics have to be cancelled.

- When children are seen in A&E/Emergency Department by the Paediatric Registrar, with injuries assessed to be non-accidental, **the Social Worker should seek a report from the examining doctor rather than book an additional medical for the child with Community Paediatrics.** If in doubt, this can be discussed with the "Consultant of the Week".