Multi-Agency Policy for Minor Injuries in Babies

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Contents

Page

1. AIM

The aim of this Policy is to ensure that professionals are aware of the significance of bruising and minor injuries in babies and know when to refer to hospital for a medical opinion.

2. TERMINOLOGY

Baby: a young and / or developmentally immature child. This Policy 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 yet be independently mobile.

Minor Injury: any injury or site of injury which may be considered insignificant in an older child including cuts, grazes, bruises, minor burns, subconjunctival haemorrhages and bleeding from the nose or mouth.

Mobile: a baby who can crawl, pull to stand, 'cruise' around furniture, or is toddling.

Non Mobile: babies who cannot do any of the above. Babies who can roll or sit independently are classed as **Non Mobile**.

NAI: Non accidental Injury

3. RESEARCH FINDINGS

- Bruising in a baby who has no independent mobility is very uncommon – less than 1%. It may be an indicator of a serious medical condition or physical abuse.
- Accidental bruising occurs in approximately 17% of babies who are cruising (1 to 5 bruises).
- Severe child abuse is 6 times more common in babies aged under 1 year than in children aged over 1.
- In one study, 30% of abused babies under 1 year had been a cause of previous concern to a health professional in relation to issues of neglect or abuse.
- Child deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission.
- Babies under 6 months of age with a brain injury are more likely to have sustained an inflicted brain injury than older babies.
- Retinal haemorrhages are rare in accidental trauma.
- Oronasal bleeding (bleeding from both the nose and mouth) in infants has been proposed as a marker of child abuse.
- Infants presenting with bleeding from the nose and / or mouth in the absence of a clear cause, warrants admission to hospital for further investigation.
- Abusive Head Trauma (AHT) – previously described as Shaken Baby Syndrome – is a relatively common cause of childhood neurotrauma with an estimated incidence of 14-40 cases per 100,000 children under the age of 1 year; 15-23% of these babies die within hours or days after the incident. Of those who survive AHT, one third are severely

disabled; one third are moderately disabled and one third have mild or no lasting symptoms.

Infants under the age of one are more at risk of being killed at the hands of another person than any age group of child in England and Wales.

4. BENIGN SKIN MARKS

This Policy refers only to injuries. Where it is believed a skin mark could be a birth mark or similar benign medical skin condition, professionals should be encouraged to use their judgement.

Professionals should also liaise with the baby's Midwife/Health Visitor / GP to establish if a diagnosis has already been made as this will be recorded in the baby's records. If any doubt exists about the nature of the skin mark, the baby's parents / carers should seek a medical opinion from their GP.

NB In order to avoid unnecessary concern at a later date it is imperative midwives/paediatricians record birth marks or marks/bruises sustained during the birth process or during any medical interventions during or shortly after the birth in the Personal Child Health Record (Red Book) as well as both in the midwifery and child records.

1. Benign Neonatal Subconjunctival Haemorrhages and NAI

Professionals in the community may come across a subconjunctival haemorrhage in new born babies after discharge in whom no haemorrhage was seen prior to discharge. In these cases the haemorrhage would not be documented. This is because, after birth, babies often have oedema of the eyelids and they open their eyes less widely in the first day or so making early observation and recording of this clinical sign more difficult.

Subconjunctival haemorrhages are commonly,

- A harmless feature of normal vaginal birth
- Are associated with term babies with higher birth weight and head circumference, multiparity of the mother, and rapid second stage of delivery.
- Resolve within about 14 days without treatment.

However, l*ess frequently they have been recorded as the result of non accidental trauma possibly as the result of prolonged chest or upper abdominal compression and have been associated with small facial skin haemorrhages (petechiae) and rib fractures.*

Always
When any professional is assessing a baby at whatever age with a haemorrhage it is important to consider whether they are physically well, have other minor injuries and also be aware or enquire about any safeguarding risk factors or concerns.

If haemorrhages are noticed for the first time –

- ***In a physically well baby under 14 days***

Without any other risk factors for abuse (e.g historical safeguarding concerns, domestic violence etc etc) then these are likely to have been *caused by the normal birth process* and *are harmless*. A discussion with the GP or an examination in the GP surgery my help confirm this but without further clinical concerns *a paediatric assessment is* usually *not necessary.*

- ***Babies under 14 days but where there are some additional concerns***

It is reasonable to discuss the case with a senior paediatrician such as an experienced middle grade or consultant *and* there should be an *agree*ment *on a management plan which may or may not include a thorough paediatric assessment.*

- ***Babies over 14 days of age with a new subconjunctival haemorrhage***

*These are concerning and babies should have a careful assessment to exclude medical causes or NAI. It is expected that this will be undertaken by a senior pae*diatrician as soon as possible. This should initially be referred following a discussion with the paediatric registrar on call.

Other scenarios will occur and further discussion between professionals is recommended to agree on a clear management plan which is then recorded in the child's health record. Professional disagreement suggests that more information is required or that another opinion is sought from an appropriate senior health professional and /or a named safeguarding professional.

5. ASSESSMENT

In **ALL CASES** an explanation should be sought and recorded for any visible injury observed in babies unless there are concerns that this will place the baby at risk of harm. It is imperative that the professional does **not** suggest to the parent/carer how the injury occurred.

Any explanation for the injury should be critically considered within the context of:

- **The nature and site of the injury**
- **The baby's developmental abilities**
- **The family and social circumstances including:**
    - Previous safeguarding concerns
    - Any previous injuries
    - Any unexplained child death in the family
    - Children being removed from the parent
    - Child's name currently on Child Protection Register
    - A history of domestic abuse
    - Parental substance misuse
    - Parental mental health problems
    - Parental learning difficulties

NB Consider making an Enquiry of the Child Protection Register

It is fundamental that the assessment of the family & social circumstances, including the analysis and decision making, is documented.

All those living within the family home must be considered as part of the assessment.

Other professionals eg police and social services may wish to ask parents' permission to view the parent held record in order to confirm a mark or injury has been acknowledged by a health professional.

The paediatric records, and where pertinent the maternity records, should be checked for any marks or injuries that have occurred as a result of the birth itself or as a result of historical medical treatment. For practical reasons, this may need to occur after referring to the Paediatrician and at the time of the medical examination.

6. NON MOBILE BABIES WITH A MINOR INJURY

Due to the increased likelihood of an injury in a non-mobile baby being non – accidental **ALL** non-mobile babies presenting with an injury should be referred to the Princess of Wales Hospital or Morriston Hospital Paediatric Assessment Unit for a medical opinion.

7. MOBILE BABIES WITH A MINOR INJURY

Where a Professional has assessed that Hospital Paediatric examination is NOT required for a mobile baby, consideration should still be given as to whether it is felt the baby has suffered or is at risk of suffering significant harm.

Where the baby is **known** to Social Services the professional must always contact the allocated Social Worker to make him / her aware of events and discuss any actions taken or required.
Where the baby is **not known** to Social Services but the professional deems the baby to be at risk of significant harm a referral to Social Services must be made following the All Wales Child Protection Procedures (2008). Professionals should contact their line manager /safeguarding lead urgently if they require advice/guidance in following this process.

8. BABIES WITH A MINOR INJURY PRESENTING AT AN EMERGENCY DEPARTMENT or MINOR INJURY UNIT (MIU)

Non-mobile babies - Whenever possible, all non-mobile babies must be seen by the ED Consultant who will be aware that It is very likely that non- mobile babies will also need a specialist paediatric review. Only the ED consultant can make the decision for the baby not to be referred to a paediatrician having assessed the injury and considered factors outlined in point 5.

In the case where an E.D consultant examination is not possible (e.g not on site) and the baby has been assessed by another senior, suitably experienced professional, then the responsible ED consultant must be contacted for advice. If no specialist paediatric referral is needed then the reasons must be clearly recorded in the medical notes. **The default position is that non- mobile babies are referred to either ED in Morriston Hospital, Swansea or in Princess of Wales Hospital, Bridgend**

Mobile babies will more commonly have accidents however these must also be assessed by a suitably experienced professional such as the ED Middle Grade Doctor or Consultant, Advanced Nurse Practitioner or Emergency Nurse Practitioner. If a doctor or professional of

this grade and experience is not available the baby should be referred to the Paediatric Registrar for specialist assessment.

9. MAKING A REFERRAL TO THE HOSPITAL PAEDIATRIC SERVICE

Where the professional has identified that a referral should be made to the Hospital Paediatric Service the baby's parent / carer should be informed that a person with parental responsibility will be required to attend with their baby and will be asked for consent for a medical examination to take place. Parents/carers should also be informed that if tests/further investigations are required this may take several hours and may necessitate an overnight stay.

If the baby is unknown to Social Services the professional need not contact Social Services unless there is concern that the baby has suffered or is at risk of significant harm.

If the baby is known to Social Services the professional should contact the allocated Social Worker (or the Duty Social Worker in his / her absence) as soon as possible to make them aware of events and discuss any action required. If the baby is known to Social Services the Social Worker must ensure the Paediatrician is aware of all relevant information, including historical concerns. The Social Worker may wish to attend the examination.

In order to make a referral for a medical examination, the professional should contact the On Call Paediatric Registrar in the chosen hospital to arrange for the baby to be seen.

The professional should help the parent/carer make arrangements for the baby to attend the examination and should ALWAYS contact the hospital to confirm that the baby has attended.

In a situation where the person with parental responsibility refuses consent for the baby to be medically examined and an injury has been identified, the professional should discuss the case with their manager as matter of priority. The manager should contact their Designated Lead for Child Protection (Social Services) or in the case of Health Professionals, the Named Doctor for Safeguarding Children or the Consultant Paediatrician on call, to establish whether medical examination is definitely required. **If an examination is deemed necessary, Social Services' immediate involvement is essential and a referral should be made by the attending professional.**

10. THE MEDICAL EXAMINATION

The Paediatrician should perform the medical examination taking into account the developmental capabilities of the baby and all information provided when the cause of the injury is being assessed.

Accidental Cause

- If the cause of the injury is felt to be accidental, the Paediatrician should still consider if the child has been, or is at risk of significant harm. If so a referral to Social Services should be made in accordance with the All Wales Child Protection Procedures (2008).
- If the baby already has an allocated Social Worker, the Paediatrician must ensure he / she is informed of the outcome of the medical examination.
- The Paediatrician must inform the referring professional of the outcome of the medical examination and of any action being taken.

Non-Accidental Cause

- If the cause of the injury is felt to be non-accidental the Paediatrician must take steps to immediately safeguard the baby according to the All Wales Child Protection Procedures (2008) and organisational safeguarding procedures. This will include **immediate** referral to Social Services if the baby is unknown to that agency.

- The Paediatrician must discuss with the Social Worker the outcome of the medical examination and any follow-up action required. Both should be clear about what actions are to be taken and who is responsible for implementing these actions. This will include reporting to the Police without delay where there is concern about a child's welfare which constitutes or may constitute a criminal offence against a child. This is to protect the baby and any other children from risk of serious harm.

- The Named Doctor Safeguarding Children must be informed of **ALL** non-accidental injuries.

- The referring professional must be informed of the outcome and of any action being taken.

- Nursing staff in the hospital must inform and update the relevant safeguarding nurse specialists who can then liaise with relevant professionals.

- The relevant safeguarding nurse must ensure the Named Nurse for Safeguarding Children is aware of any non-accidental injuries.

- All discussions and outcomes should be recorded in the medical notes.

11. RELATED POLICIES, PROCEDURES AND GUIDANCE

- All Wales Child Protection Procedures (2008)
  http://www.childreninwales.org.uk/areasofwork/safeguardingchildren/awcpprg/proceduresandprotocols/index.html

- Procedural Response to Unexpected Deaths in Childhood (PRUDIC) 2014
  http://howis.wales.nhs.uk/sitesplus/888/document/338511

  - PRUDIC Revised Flowchart –
    http://howis.wales.nhs.uk/sitesplus/888/document/338510

- Birth Planning Guidance for Midwives and Social Workers

  http://staffnet/media/pdf/b/s/cfpol-joint-birth-planning-guidance-200811.pdf

- NSPCC information leaflet
  http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html
- Cardiff Child Protection -Systematic Reviews
  http://www.core-info.cardiff.ac.uk/

12. RESEARCH:

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3. McIntosh N, Mok JY, Margerison A Epidemiology of oronasal hemorrhage in the first 2 years of life: implications for child protection. *Pediatrics* 2007; **120**(5):1074-8

4. 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

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6. Shreiti Agrawal et al. Prevalence of Retinal Haemorrhages in Critically Ill Children. Pediatrics 2012; **129**;e 1388

7. T. Sieswerda – Hoogendocrn et al. European Journal of Pediatrics 2012. Abuse Head Trauma. **171**:415-423

8. Maguire S, et al. Archived of Diseases in Childhood 2009. Which clinical features distinguish inflicted from non-inflicted brain injury? A systematic Review: **94**: 860-867

Minor Injuries in Babies Flow Chart

Professional Involved With Family

New mark / injury observed by Professional
(**NB**... ALL birth injuries/marks MUST be recorded in PCHR and Midwifery records PRIOR to discharge from hospital).

This looks like a new injury or previously unrecorded bruise...

This could well be a birth mark or medical skin condition...

Document the (birth) mark and reassure family, as appropriate

OR

- Refer for advice to **GP**
- Ask advice from your senior

Is the baby Mobile ?

This baby is **NON MOBILE**

* If already known to Social Services then consider contacting worker before Referral.

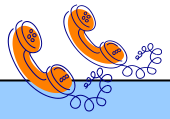
I know this baby **is MOBILE** (can walk or can crawl and pulls to stand...)

I still have some concerns that this may well be a Non Accidental Injury...

Refer to social services

History is consistent with injury and I have no other safeguarding or medical concerns

Paediatric Assessment Unit



Medical Assessment by **PAEDIATRICIAN**

Paediatric Assessment Unit
Morriston - 01792 706103
Princess of Wales - 01656 752517
Neath Port Talbot – Not Applicable

Contact hospital and discuss with on call Middle Grade Paediatrician.
Morriston - 01792 702222
POWH - 01656 752752

This was accidental

This is a skin / medical condition

Discharge

Treat as appropriate

Likely due to **Non-Accidental Injury**

Ensure admission for safeguarding concerns and further investigation.

Investigations as advised by Consultant Paediatrician

Discharge
Strategy meeting **prior** to discharge with Social Services to agree future plan.

Refer to Social Services to alert to likely cause of injury and planned investigations

Out of hours
Swansea - 01792 635700 / 775501
Neath/Pt Talbot - 01639 686803 / 895455
Bridgend - 01656 642320 / 01443.425012

Named Doctors Safeguarding Children:

Dr Andrea Warlow 01792 517950
Dr Matthew Obaid 01656 752661

Safeguarding Office: 01639 683164