1. Introduction and Who Guideline applies to

This Guideline is designed to ensure staff in University Hospitals of Leicester NHS Trust (UHL) can recognise and respond to cases appropriately where a child or young person presents with an injury of concern.

This guidance outlines patterns of bruising, marks or injury that could be indicative of physical abuse to any child or young person and the practitioner's response to these presentations where non-accidental injury is suspected.

This Guideline should also be read in conjunction with the Leicester and the Leicestershire and Rutland Safeguarding Children Partnerships Procedures.

- Bruising, Marks, or Injury of Concern in Pre-Mobile Babies and Non-Independently Mobile Children
- Recognising Abuse and Neglect

2. Guideline Standards and Procedures

2.1 Making the decision as to whether an injury is a result of child abuse or not is stressful for both the family involved and the clinical team. It is not a decision that is taken lightly.

2.1.1 Any bruising (however faint or small), fractures, bleeding, or other injuries such as burns should be considered as possible indicators of child maltreatment and should be investigated appropriately, regardless of the explanation given by carer.

2.2 Recognising maltreatment

2.2.1 It can sometimes be difficult to recognise whether an injury has been caused accidentally or non-accidentally, but it is vital that all professionals concerned with children are alert to the possibility that an injury may not be accidental and seek appropriate expert advice. Medical opinion will be required to determine whether an injury has been caused accidentally or not.

2.2.2 Any injury in an infant should raise concerns about maltreatment. The RCPCH Child Protection Evidence[2] reviews have shown that the younger the child the greater the likelihood of maltreatment. Maltreatment is the most common mechanism of severe injury in non-mobile babies.

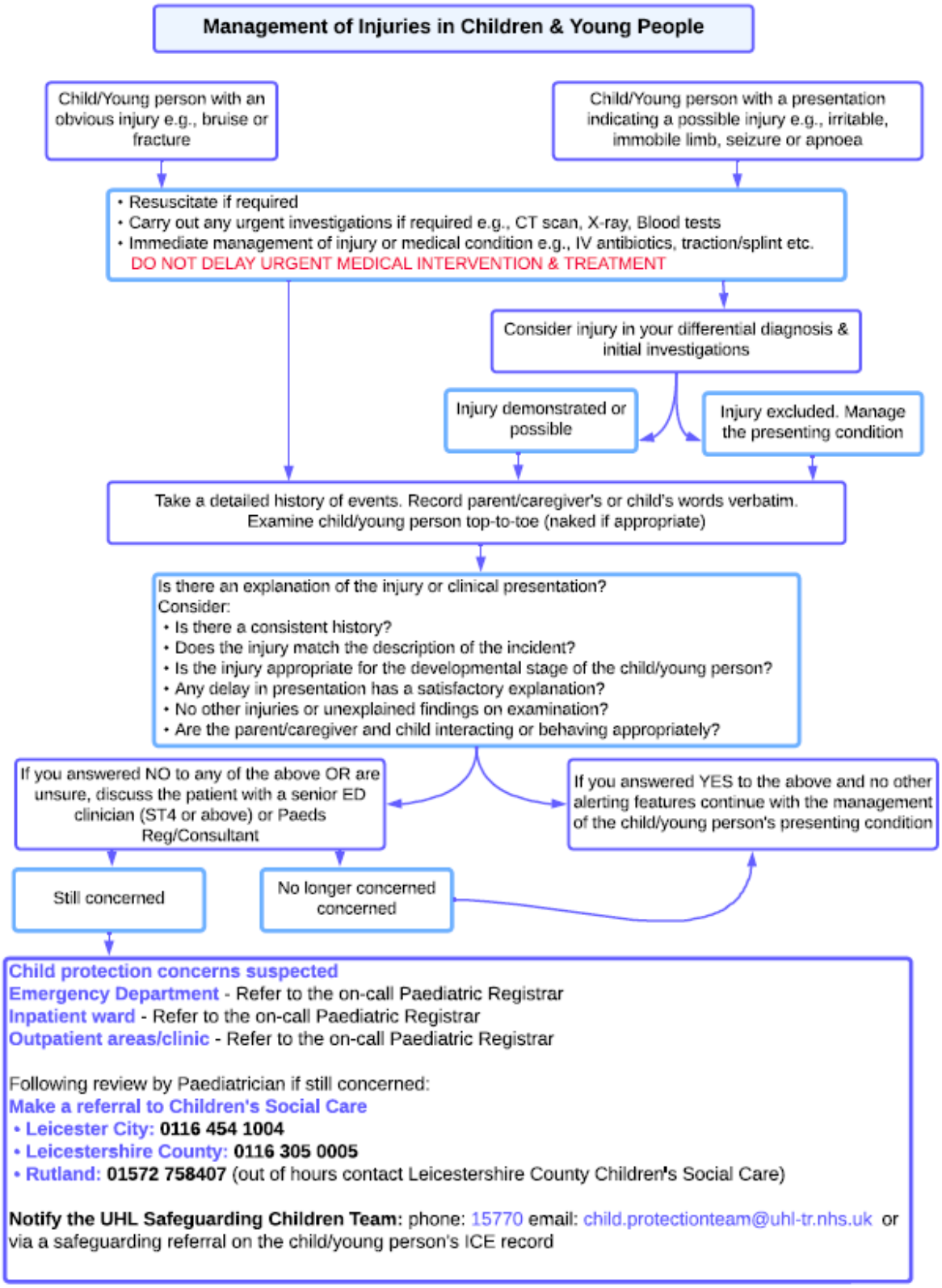
2.2.3 Although bruising, marks and injuries are common in older mobile children, they are rare in infants that are immobile, particularly those under the age of six months.

2.2.4 While up to 60% of older children who are walking have bruising, it is found in less than 1% of non-independently mobile infants

2.2.5 All injuries must be considered individually in the context of the history, age, and development of the infant and other available information.

2.2.6 On presentation, medical treatment may be the more urgent priority. This includes ABC assessment, resuscitation, and immediate treatment of injury. However, the possibility of maltreatment should be considered early in the process and appropriate safeguarding procedures should commence as soon as possible.

2.3 Management of Children & Young People with injuries



2.4 Bruising Patterns

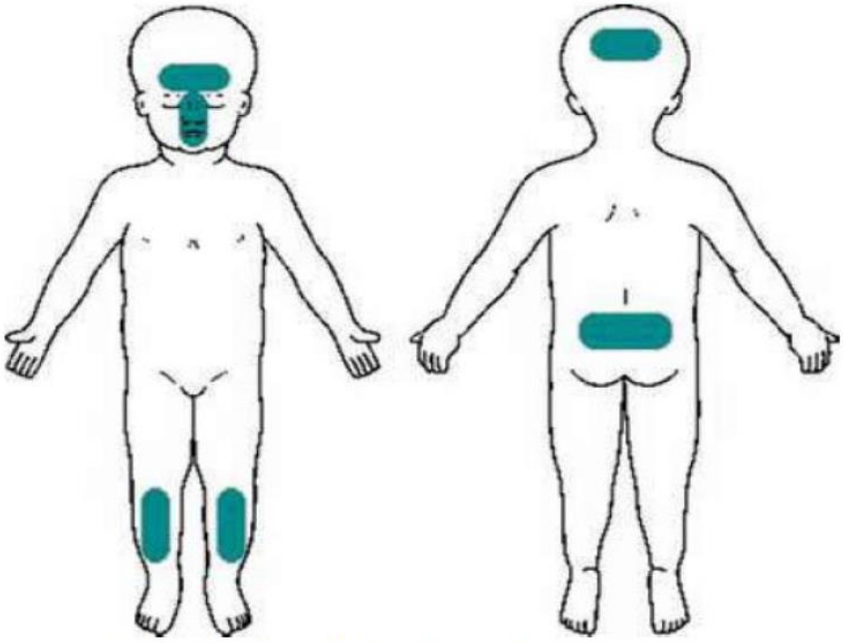


Fig 1 – Accidental Bruising patterns

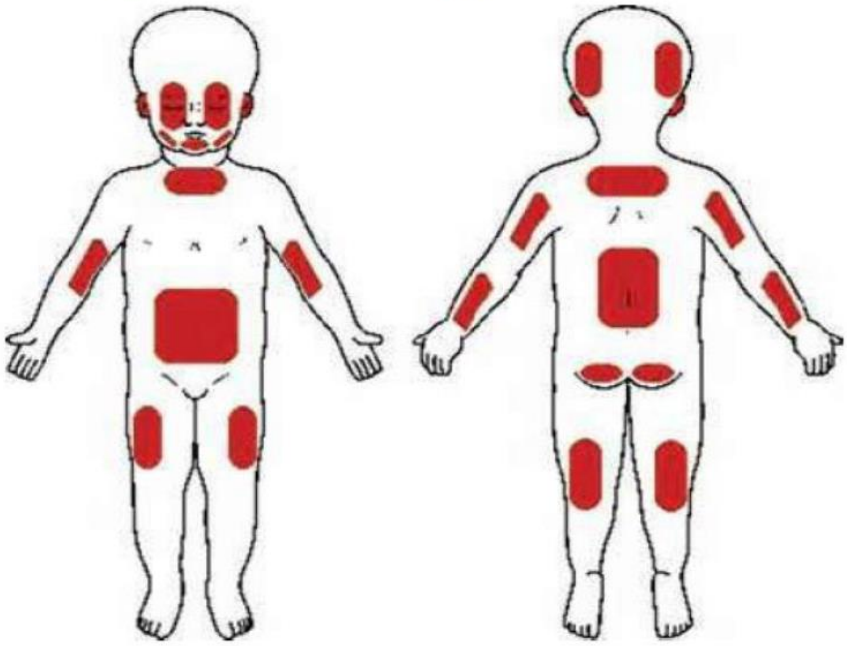


Fig 2 – Non-accidental bruising patterns

S. Maguire (2010)[1]

2.4.1 The body maps are a quick reference guide that show a comparison between accidental injury and typical features of non-accidental injuries that should prompt consideration of whether physical abuse is taking place.

2.5 Unsuitable explanation

2.5.1 An unsuitable explanation for an injury or presentation is one that is implausible, inadequate, or inconsistent:

- with the child or young person's
  - presentation
  - normal activities
  - existing medical condition
  - age or developmental stage
  - account compared to that given by parent and carers
- between parents or carers
- between accounts over time.

  An explanation based on cultural practice is also unsuitable because this should not justify hurting a child or young person.

2.6 Practitioner actions

2.6.1 Listen and observe

Identifying or excluding child maltreatment involves piecing together information from many sources so that the whole picture of the child or young person is taken into account. This information may come from different sources and agencies and includes:

- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party. It is standard practice to refer to children's social services when a child or young person makes a disclosure of maltreatment (even though it may not be precise in every detail).
- child's appearance
- child's behaviour or demeanour
- symptoms
- physical signs
- result of an investigation
- interaction between the parent or carer and child or young person.

2.6.2 Seek an explanation

Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner.

Disability

Alerting features of maltreatment in children with disabilities may also be features of the disability, making identification of maltreatment more difficult.
You may need to seek appropriate expertise if they are concerned about a child or young person with a disability.

2.6.3 Record

- Record in the child or young person's clinical record exactly what is observed and heard from whom and when.
- Record why this is of concern.

At this point, you may consider, suspect, or exclude child maltreatment from the differential diagnosis.

2.7 Consider, suspect, or exclude maltreatment

2.7.1 Consider - Vulnerability Factors & Alerting Features in the Identification of Abuse

Situations that should cause particular concern for professionals include:

- Parent/carer delay in seeking medical advice;
- If the bruise, mark or injury was found incidentally during another contact or appointment (e.g. whilst giving immunisations);
- Inadequate explanations or unlikely explanations
- Explanation is inconsistent/changes over time or confused.
- Inconsistent with the child's development stage
- The bruise, mark or injury being unexplained
- Involving other children or animals
- Lack of parental supervision (including incidents where previous professional advice has been given)
- Repeated episodes of presenting with bruises, marks, and injuries
- Risk factors: domestic abuse, mental health, substance abuse.

2.7.2 When hearing about or observing an alerting feature or vulnerability factor as a professional you must also:

- look for other alerting features of maltreatment in the child or young person's history, presentation, or parent– or carer–interaction with the child or young person now or in the past.

  Then do the following:

- Discuss your concerns with a more experienced colleague (ST4 and above), paediatric registrar or consultant, the safeguarding children team, or the named doctor for safeguarding children.
- Gather additional information from other agencies and health disciplines about the child and family.
- Medical assessments and examinations where concerns exist with the injury should be carried out in the presence of a named chaperone. The chaperone should be a qualified health professional, who is there as a witness and to support the child and clinician. Their name should be recorded in the notes.

2.7.3 Suspect

- If you believe that a child is at immediate risk, this should be reported without delay to Leicestershire Police on the emergency number 999. Non-emergency reporting can be made by calling 101.
- If child maltreatment is suspected, the child or young person needs to be a referred to children's social care, following local multi-agency safeguarding arrangements.
    - Leicester City Children's Social Care - 0116 454 1004
    - Leicestershire County Children's Social Care – 0116 305 0005
    - Rutland Children's Social Care – 01572 758407 (Out of hours contact Leicestershire County)
- If maltreatment is suspected, the child or young person needs referring to the on-call Paediatric Team/Consultant
- Notify the safeguarding children team by completing a safeguarding referral on the child or young person's ICE record or phone on ex. 15770
- This may trigger a child protection investigation; supportive services may be offered to the family following an assessment or alternative explanations may be identified.
- Use the Safeguarding Children Policy for additional guidance and support
- Inform the family of your concern (unless to do so would put the child at risk) and advise them of the safeguarding process.
- Provide the family with a copy of the Information Leaflet **'What happens when your child needs a Child Protection Medical Examination.'** This is available via YourHealth
- Document all conversations and observations within the child/young person's hospital notes

2.7.4 Exclude

Exclude maltreatment when a suitable explanation is found for alerting features. This may be the decision following discussion of the case with a more experienced colleague or after gathering additional information as part of considering child maltreatment.

2.8 The Type of Injury

See Body Maps above and further guidance below.

2.8.1 Bruising:

- Suspect child maltreatment if a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.
- Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable.

Examples include:

- Bruising in a child who is not independently mobile
- Multiple or clustered and/or of a similar shape and size.
- On the ankles and wrists that look like ligature marks.
- On the neck that looks like attempted strangulation.
- On any non-bony part of the body or face including the eyes, ears and buttocks.

2.8.2 Bites:

- Suspect child maltreatment if there is a report or appearance of a human bite mark that is thought unlikely to have been caused by a young child.
- Consider neglect if there is a report or appearance of an animal bite on a child who has been inadequately supervised.

2.8.3 Lacerations, abrasions, or scars:

- Suspect child maltreatment if a child has lacerations, abrasions or scars and the explanation is unsuitable. Examples include lacerations, abrasions, or scars:
    - on a child who is not independently mobile
    - that are multiple
    - with a symmetrical distribution
    - on areas usually protected by clothing (for example, back, chest, abdomen, axilla, genital area)
    - on the eyes, ears, and sides of face
    - on the neck, ankles and wrists that look like ligature marks.

2.8.4 Burn or scald injuries:

- Suspect child maltreatment if a child has burn or scald injuries if the explanation for the injury is absent or unsuitable **or**
- if the child is not independently mobile **or**
- on any soft tissue area that would not be expected to come into contact with a hot object in an accident (for example, the backs of hands, soles of feet, buttocks, back) **or**
- in the shape of an implement (for example, cigarette, iron) **or**
- that indicate forced immersion, for example:
    - scalds to buttocks, perineum, and lower limbs
    - scalds to limbs in a glove or stocking distribution
    - scalds to limbs with symmetrical distribution
    - scalds with sharply delineated borders.

2.8.5 Cold injury:

- Consider child maltreatment if a child has cold injuries (for example, swollen, red hands or feet) with no obvious medical explanation.
- Consider child maltreatment if a child presents with hypothermia and the explanation is unsuitable.

2.8.6 Fractures:

- Suspect child maltreatment if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity) or if the explanation is absent or unsuitable. Presentations include:
    - fractures of different ages
    - X-ray evidence of occult fractures (fractures identified on X-rays that were not clinically evident). For example, rib fractures in infants.

2.8.7 Intracranial injuries:

Suspect child maltreatment if a child has an intracranial injury in the absence of major confirmed accidental trauma or known medical cause, in one or more of the following circumstances:

- the explanation is absent or unsuitable
- the child is aged under 3 years
- there are also:
    - retinal haemorrhages or
    - rib or long bone fractures or
    - other associated inflicted injuries
- there are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage (damage due to lack of blood and oxygen supply) to the brain.

2.8.8 Eye trauma:

Where there are retinal haemorrhages or injury to the eye in the absence of major confirmed accidental trauma or a known medical explanation, including birth-related causes.

Sub-conjunctival haemorrhages in newborn babies

A sub-conjunctival haemorrhage is bleeding under the conjunctiva; the transparent layer that covers the sclera (white part of the eye). The bleeding is due to rupture and leaking of blood vessels in the conjunctiva. Sub-conjunctival haemorrhages are a frequent finding in otherwise healthy new-born infants and may be caused by rupture of sub-conjunctival vessels during delivery. The extent of the bleeding may be large or small but is always confined to the limits of the sclera. They are asymptomatic, do not affect the infant's vision and usually resolve in ten to fourteen days. Sub-conjunctival haemorrhages in new-borns can be difficult to see and may not be obvious until the baby starts to open their eyes more.

Infants can develop a subconjunctival haemorrhage for a number of

reasons:

- They are a frequent finding in otherwise healthy new-born infants and may be caused by rupture of sub-conjunctival vessels during vaginal delivery.
- More rarely they may be caused by non-accidental head injury, including shaking.
- Accidental head injury
- Forceful vomiting or coughing – typically paroxysms of coughing
- Bleeding disorders
- Eye infection

Subconjunctival haemorrhages (unilateral or bilateral) are normal physiological occurrences in newborn infants up to and including 14 days post birth, therefore isolated Subconjunctival haemorrhages where there are:

- No existing or previous safeguarding concerns
- Following examining child from head to toe there are no other signs of injury (e.g. bruising, bleeding, swelling, petechial rash including the scalp and fontanelle).
- There are no family risk factors (e.g. domestic violence, drug and alcohol use, mental health concerns, abnormal parental interactions with infant and learning disabilities)

Do not require a child protection medical or referral to the safeguarding children team. If unsure, please discuss with the consultant on call or the safeguarding children team on 15770

Subconjunctival haemorrhages seen after day 14 post birth, and in the absence of previous documentation by a health professional, require referral to the on-call Paediatric Registrar and the UHL Safeguarding Children Team.

2.8.9 Spinal injuries:

Suspect physical abuse if a child presents with signs of a spinal injury (injury to vertebrae or within the spinal canal) in the absence of major confirmed accidental trauma. Spinal injury may present as:

- a finding on skeletal survey or magnetic resonance imaging
- cervical injury in association with inflicted head injury
- thoracolumbar injury in association with focal neurology or unexplained kyphosis (curvature or deformity of the spine).

2.8.10 Visceral injuries

Suspect child maltreatment if a child has an intra-abdominal or intrathoracic injury in the absence of major confirmed accidental trauma and there is an absent or unsuitable explanation, or a delay in presentation. There may be no external bruising or other injury.

2.8.11 Oral injury

Consider child maltreatment if a child has an oral injury and the explanation is absent or unsuitable.

2.8.12 Ano-genital signs and symptoms

- Suspect sexual abuse if a girl or boy has a genital, anal or perianal injury (as evidenced by bruising, laceration, swelling or abrasion) and the explanation is absent or unsuitable.
- Suspect sexual abuse if a girl or boy has a persistent or recurrent genital or anal symptoms (for example, bleeding or discharge) that is associated with behavioural or emotional change and that has no medical explanation.
- Suspect sexual abuse if a girl or boy has an anal laceration, and constipation, Crohn's disease and passing hard stools have been excluded as the cause.
- Consider sexual abuse if an anus exhibiting dynamic anal dilation in a girl or boy is observed during an examination and there is no medical explanation (for example, a neurological disorder or severe constipation).
- Consider sexual abuse if a girl or boy has a genital or anal symptom (for example, bleeding or discharge) without a medical explanation.
- Consider sexual abuse if a girl or boy has dysuria (discomfort on passing urine) or ano-genital discomfort that is persistent or recurrent and does not have a medical explanation (for example, worms, urinary infection, skin conditions, poor hygiene or known allergies).
- Consider sexual abuse if there is evidence of one or more foreign bodies in the vagina or anus. Foreign bodies in the vagina may be indicated by offensive vaginal discharge.

If Sexual abuse is suspected DO NOT undertake a sexual abuse examination. These should not be undertaken by staff at UHL as they are not trained to undertake this work.

Follow the Guideline for the Management of Suspected Sexual Abuse in Children and Young People for additional guidance and support on the management of suspected sexual abuse.

2.8.13 Apparent life-threatening event

- Suspect child maltreatment if a child has repeated apparent life-threatening events, the onset is witnessed only by one parent or carer and a medical explanation has not been identified.
- Consider child maltreatment if an infant has an apparent life-threatening event with bleeding from the nose or mouth and a medical explanation has not been identified.

2.8.14 Poisoning

Suspect child maltreatment in cases of poisoning in children if:

- there is a report of deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs **or**
- there is unexpected blood levels of drugs not prescribed for the child **or**
- there is reported or biochemical evidence of ingestions of one or more toxic substances **or**
- the child was unable to access the substance independently **or**
- the explanation for the poisoning or how the substance came to be in the child is absent or unsuitable **or**
- there have been repeated presentations of ingestions in the child or other children in the household.

Consider child maltreatment in cases of hypernatraemia (abnormally elevated levels of sodium in the blood) and a medical explanation has not been identified.

2.8.15 Submersion injury:

If a child has a non-fatal submersion incident (near-drowning) and the explanation is absent or unsuitable, or if the child's presentation is inconsistent with the account.

2.9 Additionally, *consider* physical abuse/maltreatment if there is/are any of the following:

2.9.1 General injuries:

If the explanation for a serious or unusual injury is absent or unsuitable.

2.9.2 Pattern of the injury:

e.g.- a shoe imprint on the shin is likely non accidental due to the pattern of the injury despite it is being on a site that is common site for accidental mechanism.

2.9.3 The child's behaviour towards their parent or carer shows any of the following, particularly if they are not observed in the child's other interactions:

- Dislike or lack of cooperation.

- Lack of interest or low responsiveness.
- High levels of anger or annoyance.
- Passivity or withdrawal.

The younger the child, the greater the risk that bruising is non-accidental and the further potential risk.

2.10 The Developmental Stage of the child

The age and stage of development of the child are crucial considerations in forming a professional judgement. For example, there may be delay in the child's motor skills that does not fit with parental explanation of how the child sustained the bruise mark or injury.

2.11 Involving Parents or Carers

2.11.1 The Parent/carer explanation:

Ask and record the parent/carer response about the history of the bruise, mark, or injury (ask open questions):

- When was it first noticed?
- How did it first look/appear?
- How did it happen?
- When did it happen?
- Where did the incident occur?
- Did anyone see it happen?
- What did they think about the bruise, mark or injury, were they concerned?
- What action did they take at the time?
- How did the child respond?
- Was the child cared for by anyone else recently? Record name of additional carers

In addition,

- Observe the child's demeanour and any interactions between the child and parent/carer
- Where possible and practicable further examine the child

2.11.2 If you are not satisfied with the assessment outcome and parental response or the mark, injury or bruise, no matter how small, continues to raise suspicion and concern, an immediate contact with Children's Social Care is required to discuss the information recorded and determine if further action is required. (see section 2.7.3 for details)

2.11.3 The decision to refer to Children's Social Care, the UHL Safeguarding Children Team, and the paediatric team should be explained clearly, frankly, and honestly with consideration of professional transparency to the parents/carers.

2.11.4 In the interest of duty of candour, whenever possible, parents/carers should be included in the decision-making process, unless it poses a further risk to the child or

to do so would jeopardise information gathering, e.g. information or evidence could be destroyed, or if it would pose further risk to the child.

2.11.5 Professionals must explain to carers at an early stage why the bruising or marks cause concern and discuss the need for further examination by "a specialist" i.e. paediatrician.

2.11.6 Professionals should inform the carer/parent of the referral. Best practice is to seek consent from parents or caregivers to make the referral, unless the practitioner feels this would place the child at risk of further harm. However, the carer/parent does not need to consent, and lack of consent can be overridden in the best interest of the child as the "welfare of the child is paramount."

For further advice and guidance on information sharing in safeguarding cases please refer to the Department of Education information sharing guidance.

2.11.7 If a parent or carer is uncooperative or refuses to take the child for further assessment, this should be reported immediately to Children's Social Care, and a safety plan mutually agreed.

2.11.8 The safeguarding children team can be contacted for assistance and support when liaising with parents and carers.

2.12 Child Protection Handbook for Staff

For further information on child protection please visit the child protection handbook. This has useful information which can be accessed from a computer or from your phone.

The Handbook can be accessed here via the QR code

3. Education and Training

This policy will be disseminated via the Trust Policy and Guideline Library via UHL Connect. It will also be available on the Child Protection pages on UHL Connect.

Awareness of the policy will be raised within Trust's safeguarding training.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Correct use of the Guideline	Individual case review Feedback via Serious Case Reviews/ Serious Incident	Michelle Kelly	Case by case basis	

	Learning Processes			

5.Supporting References

1. Maguire, S. (2010). Which Injuries May Indicate Child abuse? *Archives of Disease in Childhood - Education and Practice*, 95(6), pp.170–177. doi:https://doi.org/10.1136/adc.2009.170431.
2. RCPCH (2022). *Evidence & Reviews – RCPCH Child Protection Portal*. [online] childprotection.rcpch.ac.uk. Available at: https://childprotection.rcpch.ac.uk/child-protection-evidence/ [Accessed 3 Jan. 2024].
3. NICE (2017). *Child maltreatment: when to suspect maltreatment in under 18s*. [online] National Institute for Health and Care Excellence. Available at: https://www.nice.org.uk/guidance/CG89/chapter/Recommendations#physical-features.
4. RCPCH (2021) Child Protection Companion Chapter 9: Recognition of Physical Abuse. [online] childprotection.rcpch.ac.uk. Available at: CPC_Chapter-09_Recognition-of-Physical-Abuse_v4_131221-for-PDF.pdf
5. Department for Education (2024) *Information Sharing Advice for Practitioners Providing Safeguarding Services for children, Young people, Parents and Carers*. Available at: https://assets.publishing.service.gov.uk/media/66320b06c084007696fca731/Info_sharing_advice_content_May_2024.pdf.

6. Key Words

Maltreatment. Accidental injury. Non-accidental injury. Child protection. Physical abuse

7. Legal Liability Guideline Statement

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

This line signifies the end of the document

This table is used to track the development and approval and dissemination of the document, and any changes made on revised / reviewed versions

Contact and Review Details	
Guideline Lead: Michelle Kelly	**Executive Lead: Michael Clayton**

Details of Changes made during review:

- Slight re-wording of flow-chart
- Section 2.7.3 - addition of details on contacting Police with immediate concerns
- Section 2.8.8 - Eye Trauma. Addition of section of 'Sub-conjunctival haemorrhages in newborn babies
- Section 2.11.6 - addition of hyperlink to Department of Education Information sharing guidance – reference also added to reference list