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<u>Document title</u>	<u>BRUISING AND SUSPECTED NON-ACCIDENTAL INJURIES(NAI) IN CHILDREN AND YOUNG PEOPLE</u>
<u>Document description</u>	The aim of this protocol is to provide frontline professionals with a knowledge base and action strategy for the assessment, management and referral of children of different ages in the context of suspected child physical abuse.
<u>Document authors</u>	<u>Version 1</u> Dr A Freiberg, Community Paediatrician, iDD Children Safeguarding LBE Chantel Palmer, Designated Nurse, Children Safeguarding, NCL ICB <i>Acknowledgements to: Dr Paul De Keyser and the Barnet SCP (for sharing the root document on which this version is based); to Carolyn Sobers Safeguarding Children lead, Enfield Community Health; to Tomm Wolfram</i>
<u>Target audience</u>	All professionals who routinely encounter pre-mobile infants, children or young people, especially in a community setting - <i>particularly those professionals whose main job is not dedicated to safeguarding.</i>

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BRUISING AND SUSPECTED NON-ACCIDENTAL INJURIES (NAI) IN CHILDREN AND YOUNG PEOPLE (ALL CATEGORIES)

A multi-agency protocol for assessment, management, and referral by professionals within the Borough of Enfield

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Key messages ...

Key Messages

Bruising is the commonest presenting feature of physical abuse in children. Professionals might come across a wide variety of clear or unclear marks, bruises or injuries in children and young people (CYP), sometimes in unexpected circumstances. Alternatively, professionals might hear an allegation that makes them worry. There is important case-to-case variation; it is not possible to cover all circumstances. However, it might still be helpful to remember and manage a few basic principles well. When child physical abuse (CPA) is suspected, professionals are expected to exercise their judgement, follow local safeguarding policies, gather information and decide on next steps. This document hopes to inform such judgement, share knowledge between agencies, and take a step towards a “common mental map” that helps professionals fulfill their duty to safeguard children.

Identifying bruises and thinking of first steps.

Communication between professionals is essential. Although there are some common elements in CPA (many discussed in this document) every situation is different, and case-to-case variation can be almost infinite. **General principle:** if in doubt, it is best to err on the side of caution and seek advice.

A bruise is a mark on skin representing broken blood vessels underneath. Their appearance is well known. Their colour fades over several days as the blood pigment breaks down, from purple bluish to yellow green, but is not possible to “age” bruises with any accuracy based on their colour (see Glossary). Once concerns trigger a consultation process, necessary action plans can be time-consuming and stressful for all involved, including children. Hence, facing an unclear mark, professionals could first ask themselves whether what they are seeing is actually a (new) bruise or injury.

1. There may be circumstances that may not require additional safeguarding enquiries.

- 1.1.1 General considerations include checking whether other professionals (i.e., at nursery or GP practice) are aware of known birthmarks or permanent marks from known medical conditions. Many babies have blue grey birthmarks (especially mixed ethnic groups) on their lower back and (occasionally) in other areas, which are still a source of unnecessary referrals. For different types of birthmarks and some transient baby rashes, please see for instance here: <https://www.nhs.uk/conditions/birthmarks/#:~:text=Blue%2Dgrey%20spots&text=are%20there%20from%20birth,sign%20of%20a%20health%20condition>
- 1.1.2 Apart from blue grey “buttocks” birthmarks, there may be others called “café-au-lait” spots (because of their colour), red ones, like “strawberry nevi”, moles, or transient pink marks on babies’ foreheads and nape of neck called “stork bite”, and sometimes marks related to trauma during birth (i.e., from forceps or ventouse). If in doubt, check with parents, health visitor, and especially midwives.
- 1.1.3 Birthmarks and, especially, bruises due to traumatic delivery are usually well known and should have been documented by Hospital staff; there is often a note or even body maps in the Red Book or midwifery files. Signs of traumatic delivery are expected to improve with time. Birthmarks change really slowly or sometimes not at all, so in all likelihood they would have been seen before in the same setting. If the origin remains unclear after initial enquiries, please seek advice, especially if the mark is seen in a pre-mobile infant (in babies).
- 1.1.4 Children with eczema: these children have skin changes all the time, sometimes quite obvious during flare-ups. They also scratch themselves leading to lines and colour changes. However, bruises or clearly odd marks are not part of eczema. Professionals could also look at whether eczema care appears appropriate.
- 1.1.5 **Special Category: Birthmarks in Looked After Children (LACs):** Here, the foster carer (FC) and/or social workers (SW) should always keep a short note recording the type and location of birthmarks, as soon as care arrangements start, in the child’s own red book, in case files, or in clinical letters, copied to the

GP. This information would also be contained in LAC health assessments, but it should be more readily available for anyone to see, in case of doubt, since these children change their GP and care arrangements more often, and even minor discrepancies with physical details have been known to find a place in disagreements between parents (custody) or with children's services.

- 1.1.6 With older mobile children, an accidental bruise could already have been noted by another professional in the same or different setting. Setting notes could clarify whether parents were duly informed of any incident, and to compare injuries to see whether the observed mark is new or not, so please consult with colleagues.
- 1.1.7 Mobile, active, healthy children are often found with common bruises or marks. A degree of judgement is to be exercised here. Enquiring professionals can try to "picture in their minds" the way an injury happened as precisely as possible (like "watching a movie"). One question could be: *is the bruise I see what I would expect to see, given the account?* Where a plausible explanation from a parent, carer or child exists; the family circumstances (as known) are not concerning; the history and explanation seems to match the child's age and ability, and there are no concerns regarding the explanation itself, or the timing and circumstances of the presentation for the type of injury seen: all conditions met, it may not be necessary to do much more than documenting it (Table 1: professional curiosity).
- 1.1.8 In general, common marks and bruises are usually well-known to parents, limited in number and located in "exposed areas" - body areas more likely to be bruised accidentally (see 3.2.1). It helps to remember that active children are usually not "covered in bruises" even in exposed areas. Although there is no "threshold" for a given number of bruises in common locations to be considered unusual, "too many common bruises" should also raise an eyebrow, as the pattern could result from, at the very least, sibling-to-sibling aggression and/or poor supervision.
- 1.1.9 To decide on low likelihood of abuse, conditions in point 1.1.6 to 1.1.8 are usually met completely and in the absence of any previous safeguarding concerns regarding the child, young person or family¹.
- 1.1.10 Having said that, if in doubt, seek advice. Please do not hesitate to discuss your concerns with trusted colleagues or your local organization safeguarding leads.

When should we be more concerned about bruises?

Bruises that could be non-accidental are labelled possible "non-accidental injuries" (NAIs). Here, and contrary to points 1.1.6 to 1.1.8 above, the observed injury, bruise or mark(s) shows characteristics which suggest it could have been *inflicted* – that is, caused by someone else, instead of resulting from an accident.

Professionals coming across an unexpected bruise would need to exercise professional curiosity to form an initial judgement in relation to the child's age: if a clear bruise is found on a pre-mobile infant (extended - for simplicity - to anyone younger than one) the expected professional reaction is more "standard", heavily leaning towards same-day referral and intervention, regardless of other considerations (point 2; figure 1 below). Thereafter, evolving age characteristics and abilities progressively add new elements for consideration in such initial judgements, many of which are individually discussed below (section 3).

Professional curiosity and "gut feeling": professional curiosity has been defined as "*where a practitioner seeks to explore and understand what is happening in someone's life, rather than making assumptions or accepting what they are told at face value*". It is impossible for any document, protocol or guidance to encompass all possibilities, so professional curiosity (professional judgement) coupled with suitable "gut feeling" (which improves with experience) are valued skills and acceptable practice. For an interesting read see material from Leeds at <https://www.leedsscp.org.uk/practitioners/working-with-families/professional-curiosity#:~:text=Professional%20curiosity%20is%20where%20a,are%20told%20at%20face%20value> and Enfield (audit) at https://www.enfield.gov.uk/_data/assets/pdf_file/0026/29681/FINAL-Safeguarding-Enfield-Newsletter_Issue-6.pdf.

Table 1: Developing professional curiosity

Suggested communication tips	Suggested observation tips
Consider trauma informed approach and choose setting carefully. Suggested elements: “We are truly sorry that we need to ask you about how this (bruise) happened... We understand this is perhaps unexpected – we wish to cause no distress and mean no accusation – however, it is our Policy, when we come across some bruises or marks, or injuries not witnessed (i.e., at school), that we just ensure the child is well and that we have a chat about it” ... “We do not wish to be intrusive... but our policy stems from learning the hard lessons of the past... hidden abuse... every year... becomes public knowledge... (we) think this most likely isn’t the case here, but still need to do our job, so we beg families to be patient and understand that, in our role, we are bound to follow certain rules including a series of steps that, on the whole, serve to protect children” ... “Child Protection is a statutory duty of all organizations dealing with children... it is a complex task that inevitably results in some parents being distressed for no fault of their own, which we truly regret, but, that when applied consistently, increases children’s overall chances to be kept safe” ... “the complexity of the situation is such that in many cases we need to make sure that we have a discussion with professionals outside this organization, who have their own processes, and sometimes, a request might need to be made to see a doctor to make sure the child is fine, and no other or internal injuries occurred” ... (CPME leaflet in Appendix I)	Facing a bruise or injury, an initial explanation is sought and recorded. It is best if the professional does not suggest to the parent or carer how the injury may have occurred. Examiners can ask themselves: <i>is the bruise(s) I see what I would expect to see, given the account? Was the event witnessed or unwitnessed, and who was present? Does the mechanism described correspond to the observed developmental abilities of the child? Is the child able to give or draw a simple account?</i> <i>Is the bruise in an exposed or non-exposed site?</i> (see 1.1.6 and 1.17) Potential concern: bruises seen away from bony prominences (non-exposed sites) around “soft tissue parts” including the ear, neck, cheeks, eyes (especially a black eye) buttocks; or in the trunk, including clavicles, upper shoulders, back, chest, abdomen, ribcage, upper arms, hands, and posterior thighs, especially in young pre-reception and primary school children. <i>Is it a single bruise or a pattern of several bruises?</i> Beware of multiple bruises in clusters in non-exposed areas including upper arm, chest, outside of the thigh, on the chest, or abdomen. <i>Does it have an odd shape?</i> Bruises that carry an odd imprint, for example of a belt buckle, handprint, or grip mark; also, long linear bruises, or those with petechiae (dots of blood under the skin) in or around them, or suggesting grip mark patterns, or resembling petechial bruising from suction (“love bites”) or any clearly unusually shaped injury or obvious mark, especially without explanation or with an implausible or unlikely explanation. Please also consider whether what is seen could be paint marks in young children. Observe interaction between children and parents and please record any non-verbal cues. It can be useful to make a drawing or ask the child or person recounting the events of the injury to make a drawing of how it happened. Observe: <i>Is there rough handling or inappropriate or disproportionate “telling off”? Significant behavioral changes to habitual? wariness or watchfulness? Alleged sibling-to-sibling aggression? Multiple injuries allegedly “all happening at the same time” i.e., in same or different areas?</i> Active children occasionally present with odd accidental bruises. Consider family and social circumstances (if known) including siblings. <i>Are there any known risk factors? Was this a significant injury with no or inconsistent explanation?</i> Or explanation that does not fit with the injury seen or the child’s physical skills; a history describing absence of pain or crying as normally expected; signs of neglect such as poor clothing, hygiene or nutrition; or reported difficulty in feeding or excessive crying for no clear reason. <i>Is there an allegation or an admission of maltreatment from parents, carers, family, or others, or any worrying statement?</i>

Apart from bruises, professionals in regular contact with children might come across **allegations**. An allegation is a narrated story which recalls, implies or suggests the presence of abuse. At any age, a clear allegation from a child or adult usually prompts discussion, MASH referral and subsequent medical examination to check for bruises. Bruising is the commonest presentation of child physical abuse (CPA) but, unless the child is examined, there is no way to know. There is already ample literature in this respect which requires dedicated reading, beyond the scope of this protocol. For further reading, see for instance https://www.londonsafeguardingchildrenprocedures.co.uk/contents.html#sq_prac_guid.

- **Important points:** Allegations require trust, and therefore, are best obtained fresh at the start, in the child’s habitual place (i.e., school, club, or home) in safe, private conversation with professionals known to the child. Allegations should be recorded “verbatim” (in the child’s own words) and included in referral as such. It might be necessary to clarify bits but please avoid asking the child to repeat the same story to various professionals too many times. Here, the child’s age and maturity are crucial. A frustrated young person who “had enough”

may have no qualms re-stating an allegation as often as asked, but young children may not react in the same way. Timeliness is paramount. Doctors and Police officers can check allegations against existing evidence (see below) but, by the time the child reaches that stage, it may be too late. Referral processes take time, creating opportunities for a child to feel (or be made to feel) guilty or intimidated. Also, unfamiliar settings and people might not help. Medical settings, for instance, would have curtains, equipment and bright lights, appropriate for examination, but not ideal for revisiting allegations in detail; children, particularly young ones, might not say much more at this stage, especially when anxious parents and relatives are around. Case-to-case variation can be quite large, so it is always advisable for the first line practitioner not to be too prescriptive with any guidance or protocol (including this one) and consult the case at hand with more experienced colleagues if in doubt.

When NAIs are suspected in the community, for instance in a school setting, a local safeguarding protocol should be activated, involving internal discussion and referral to a panel of experienced professionals (a Multiagency Safeguarding Hub – MASH). Occasionally, first contact occurs with Police officers, or ambulance staff, who have their own institutional protocols and experience and can take appropriate action, or even from parent or relatives, who need a safe space with a trained professional to discuss concerns. Depending on circumstances, MASH professionals might request a Child Protection Medical Examination (CPME); a type of medical appointment where doctors assess the number and location of injuries, their shape, sizes and overall pattern, against the developmental ability and general health status of the child(ren) and any explanation. Doctors have their own professional methods to execute these tasks to the best of their ability.

The bottom line here is that establishing whether bruising represents NAIs involves complex considerations which are not expected to be made solely at local “originator” level (i.e. by a first line professional in a school or nursery setting). **A group decision is likely better than an individual decision.** As a whole, the safeguarding *system* tends to work better when the widest possible variety of stakeholders, within their organizations or agencies, share a common “mental map” and are aware of how other agencies in their system work. The aim is for everyone, at any level of the system, to be familiar with key general considerations about possible CPA, next steps, and basic root decision-making branches.

Complexity is often cited in fragmented, relatively unresponsive safeguarding systems, so it makes sense to try to reduce it. Arguably, a common “mental map”, shared across agencies, creates a common framework to think about potential CPA by age-groups categories, especially since age is the simplest universal underlying variable and a main factor driving the type and timing of safe system response.

“THE REVIEW CONTENDS THAT MULTI-AGENCY ARRANGEMENTS FOR PROTECTING CHILDREN ARE MORE FRACTURED AND FRAGMENTED THAN THEY SHOULD BE.”

<https://learning.nspcc.org.uk/research-resources/2022/national-review-murders-arthur-labinjo-hughes-star-hobson-caspar-briefing>

2 Age at presentation: the pre-mobile baby

- 2.1** Age, physical, verbal and cognitive development go hand in hand: the explanation for an observed bruise must match the observable developmental capabilities of a child, infant, or YP.
- 2.2** Accidental bruising in pre-mobile babies is rare¹. A pre-mobile infant is one whose motor development would not normally allow for the movements necessary to cause the observed bruise, regardless of any history given.
- 2.3** The younger the child is, the higher the risk that bruising is non-accidental. To simplify categories, **pre-mobile** applies to all infants (under one year) but **especially when the baby is under 6 months**.
- 2.4** Bruising in any pre-mobile infant should prompt immediate discussion with a Safeguarding professional from the organization in which the professional works, and in a referral made to Children’s Social Care (MASH) by calling 0208 379 5555 **prior** to using the portal, currently found online at <https://cp.childrensportal.enfield.gov.uk/web/!l-openid-provider/web/oidc->

[auth?max_age=0&scope=openid+profile+email+phone&claims=%7B%7D&response_type=code&redirect_uri=https%3A%2F%2Fcp.childrensportal.enfield.gov.uk%2Fweb%2Foidc%2Fcallback&state=UAXuxdABEp7fsgPbx9979GGzCyO181-P7Ne2smk0fg&nonce=Q47VBjnrkKbyqpFSHkGx51bISd9XQ8VbEJ6pwVCwXk&client_id=portal.EnfieldLCS.liquidlogic.co.uk&response_mode=query#h1](https://portal.enfield.gov.uk/2Fweb%2Foidc%2Fcallback&state=UAXuxdABEp7fsgPbx9979GGzCyO181-P7Ne2smk0fg&nonce=Q47VBjnrkKbyqpFSHkGx51bISd9XQ8VbEJ6pwVCwXk&client_id=portal.EnfieldLCS.liquidlogic.co.uk&response_mode=query#h1). The system will ask for referrer registration and then take the user through a few quick steps before the referral is formally registered.

- 2.5 Timeliness:** the requirement to consult with their local Safeguarding professional should not prevent any individual professional referring children to Children's Social Care with bruising or a suspected NAI who, in their judgement, may be at risk of child abuse, regardless of age. If the local lead is temporarily unavailable, please follow point 2.4 above.
- 2.6 Babies with bruises or injuries are Hospital cases** ²³. Originators (referrers, i.e., professionals first coming across the bruise) should consult safeguarding leads and discuss with MASH as in 2.4. In some instances (grey cases or confusing factors) it might also be appropriate to involve the Designated Doctor (DD) at a.freiberg@nhs.net or Designated Nurse at chantel.palmer@nhs.net. When making a Hospital referral, staff should be informed using the North Middlesex CP Hospital pathway: Paediatric Registrar on call Out of hours - 0208 887 2000 Bleep 195 - or For Consultant Paediatrician Hotline - 07436283463 During Summer 09:00-5:00pm During Winter 09:00-9:00pm. See also NICE guidance "when to suspect child maltreatment" (CG 89, updated October 2017) *bruising in any child not independently mobile should prompt suspicion of maltreatment* (Overview; Child maltreatment: when to suspect maltreatment in under 18s – NICE).
- 2.7** As a general rule, please do not send babies (or any safeguarding case, of any age) to Hospital without prior discussion with Hospital doctors as above, ensuring everyone is aware.
- 2.8 Means of transport:** originators need to consider how the baby would actually arrive at destination. Any unwell infant would require ambulance services as per local emergencies protocol. For well (stable) cases, professionals should still consider whether it is safe that a baby is trusted back to parents or family to be taken to Hospital: transportation should be explicitly discussed with MASH and/or Hospital teams and records should be made of safer alternatives considered.
- 2.9** At the Hospital: Hospitals have dedicated protocols for investigating bruises, especially in pre-mobile infants (not part of this protocol). Tests might be required (usually a head scan, eye examination, blood tests, sometimes X-rays of the whole body called "skeletal surveys", etc.) which are usually done as quickly as possible. However, the process might still take a couple of days' admission, or more; it is important for all stakeholders to have this in mind, to avoid potential miscommunication.
- 2.10** When making an assessment and referral, professionals should review the information held within their agency to identify relevant or associated risk factors that might not be known elsewhere, and need to be shared with others like MASH, Hospital teams, or social workers. This may include parental risk factors or child risk factors, as known by the originating agency.
- 2.11 With babies, beware of BRUE:** First line professionals should enquire if there is an account of **BRUE - Brief Resolved Unexplained Event**: this is a healthy baby who allegedly went limp or changed colour, stopped breathing, or appeared "out of it" for a short time (less than one minute) and then "came back to normal" without any clear reason or explanation.
- 2.1.1** When facing BRUE, please follow guidance at points 2.4 and 2.6. Apart from potentially serious illnesses, a chief cause of BRUE is child physical abuse, especially what is called "shaken baby". Note that BRUEs (and shaken babies) **may not have visible bruises** and yet could have suffered internal damage and be at risk of more.
- 2.1.2** Any first line professional facing a BRUE should, at least for the time being, class the case in the **same category as an unexplained bruise in a pre-mobile baby** and remember that the

baby in question still needs to go to Hospital, since BRUE is a hospital diagnosis of exclusion. Doctors need to make sure the baby is not suffering from an unknown medical problem and will carry out a series of tests, including those in point 2.9.

2.12 Special Categories: physical disability. There are also special categories: odd or unexplained bruises or injuries found in a child or young person (CYP) deemed 'not independently mobile', should prompt suspicion of maltreatment.

2.12.1 Assessing marks or bruises in this special group can be complex. Increased prevalence of abuse is known to exist for children with added needs⁵. Here, professionals familiar with the case should carefully assess all known underlying factors, such as habitual body posture, possible movements against or contact with appliances, recurrent rocking or shaking, changes in caretakers or personnel, marks from medical procedures, devices, or tubes going "in and out" and/or other possibilities, such as movements during transport or changes of position.

2.12.2 If, after checking the above, a mark or bruise, or sometimes an unexplained clear behavioral change noticed by familiar staff, is still cause for concern, then discussion with MASH is most likely the next appropriate step, as in 2.4, most likely followed by a referral (if suitable) for Community CPME as in point 3.10 below. Special needs are also discussed below.

3 Age at presentation: mobile infants; pre-verbal toddlers and pre-reception young children

3.1 From here onwards, age categories require some individual considerations. Still, within the first year of life, it is overall safer to follow the processes above. In practice, the age at which infants become more mobile varies. The referrer would usually be familiar with the infant's range of abilities in their habitual setting (i.e. a nursery) but, occasionally, new staff, families moving in, or a different setting might mean a concerned professional is not familiar with a given case.

3.2 The first twelve months: babies can start rolling over as early as 4 months old. Initially, they would typically "rock" a bit from side to side; the foundation for rolling over. They may also roll over from tummy to back. At 6 to 7 months old, many babies can roll over in both directions. Cruising, even toddling, typically starts after one, but in some cases, it might be present after 10 months, or even as early as 9 months. **Note it is still uncommon for the limited movement ability of the first twelve months to result in significant bruising in normal circumstances.** If unknown, professionals would observe the infant and establish an individual profile of abilities.

3.3 There are many potential scenarios. Even with an explanation, accidents in infants (younger than one) tend to leave a few to no marks. Bruises in infants are usually noticed by someone who sees them happening, since curious infants, especially crawling, learning to stand or walk, can get in trouble and are seldom left alone. Obvious bruising on face, head, trunk, (especially ribcage and back) upper shoulders, clavicles, lips, earlobes, or behind the legs in a mobile infant (still younger than one) or in a young toddler, should raise an eyebrow, following the principle that it is always best to err on the side of caution. There might be a plausible explanation that matches the observed physical development of a child but not the observed location. Referrers can look at cases individually and discuss with parents that, in any case, concerning bruises are best investigated at this young age, to make sure no internal damage was caused, while recalling that, in any case, it is best to face the possibility of upsetting a family than to leave potential CPA unattended (table 1).

3.4 In general, the first year of life could be divided into pre-mobile (first six months) and potentially early mobile thereafter, based on observed physical development (red categories in figure 1 below). For simplicity, in figure 1 pathways for pre-mobile infants are extended to **all infants under one**, since, in this age group in particular, unexpected bruises should always trigger professional curiosity.

3.5 Again, the type and location of bruises should match the explained mechanism as in 3.2 and 3.3. If in doubt, for all under one year, **always follow 2.4 and 2.6 above.** Figure 1:

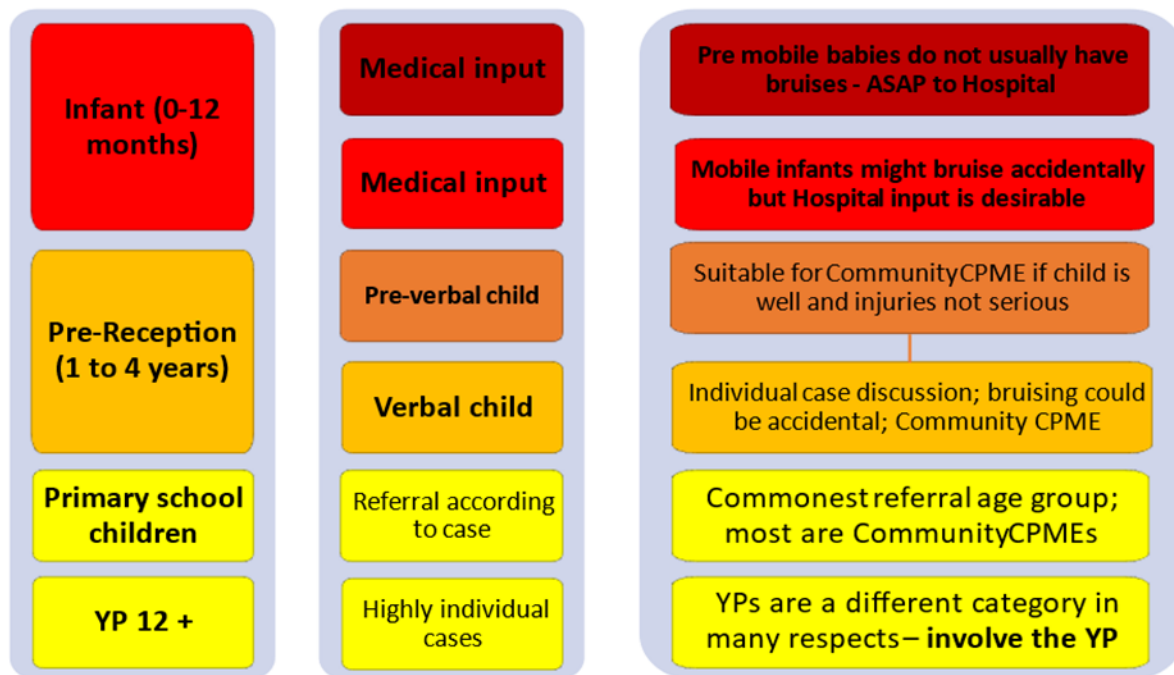


Figure 1: CPA by age groups and simplified CPME action points. Precisely determining cut-off categories is difficult, especially between the mobile infant and the verbal toddler. Colour coding is illustrative and in no way represents a “diminishing” importance of the consequences of CPA with age. CPA is equally noxious to children of all ages. Still, it might be useful for professionals to ensure that response is proportional to degrees of vulnerability within presentations, in relation to the capabilities children acquire as they grow. For instance, pre-reception age groups are young, vulnerable children, with less developed agency, smaller bodies, and “magical” thinking, at higher risk of sustaining more physical and emotional harm while being unable to communicate it. Translating this into practice, bruised infants would constitute the highest risk category, leading to same-day Hospital evaluation. Preverbal and pre-reception toddlers could be Community CPME cases if stable, although special care should be taken for the youngest in this category (pre-verbal) who might still need same-day investigations (see point 2.9). Stable primary school children would be seen in Community CPMEs, as well as YPs, whose vulnerability includes other types of risks and require a different approach. If in doubt, professionals could use this diagram to ask further questions. Lastly, any *unwell* CYP of *any* age group would still require Hospital (A&E) management.

3.6 When assessing a case, professionals can document the child’s observed level of physical development for current and future reference. In CPME reports, doctors are expected to comment on whether the observed abilities are likely to allow the child to execute the alleged movement leading to the observed bruise. This complex task is best left to experienced paediatricians.

3.7 Accidental bruising becomes more common as children grow older. Accidental bruises or marks are most likely located in “exposed” areas (forehead, elbows, outer forearms, knees, shins – what doctors call “bony protuberances”) and are usually round in shape and limited in number (Table 1). Likewise, bruising (irrespective of location) with odd shapes, groups “clusters” of several bruises together in same area (or odd patterns) and/or non-exposed location should trigger professional curiosity and prompt internal discussion assessing contextual concerns (as above and table 1) and, if still worried, a discussion or referral to MASH as in 2.4.

3.8 A young toddler with developing mobility is usually also pre-verbal. The age at which young toddlers can accurately re-tell a story is highly variable. Being preverbal increases vulnerability. Trained professionals can use interview techniques including those collectively called ABE (see <https://www.college.police.uk/app/investigation/investigative-interviewing/investigative-interviewing>) but these are generally beyond the reach of first and many second-line professionals, who can nevertheless still use other suitable methods approved within their organizations.

3.9 Hence, **preverbal children**⁴ are another vulnerable category for which professional curiosity is paramount. Any unwell or extensively bruised preverbal child should, in practice, be considered

equivalent to a bruised pre-mobile baby and placed for action points as in 2.4 and 2.6 above. Other preverbal toddlers, if well and stable, may be suitable cases for Community CPMEs (see 3.13 below).

3.10 Verbal but pre-reception children with signs of injury might be able to provide a simple story if carefully asked. Although active and mobile, their small body sizes, limited understanding and recall memory, and “magical” thinking, makes them more vulnerable than their Reception counterparts. Concerning signs as in 3.3 should still prompt discussion and referral (as in 2.4) with a low threshold of also discussing “grey” cases with the DD or DN, since case-to-case variation can increase with respect to younger age groups. Nurseries and primary care centers are potential referrers; also concerned relatives. Here, multiple or co-existing abuse is even more likely, including emotional (CEA) and signs of neglect, which might be more obvious than in younger categories. Gathering good quality information is critical. Child Protection Medical Examinations (CPMEs) are discussed on a case-by-case basis within a Strategy Meeting, ideally with representation from Police and Health agencies. If the decision at the Strategy Meeting is that a CPME is not required, this should be clearly documented with the rationale. The referrer and social worker should also consider potentially unmet medical needs and whether a medical assessment is still required outside of the context of a CPME. The timing of a CPME in this age group should be determined by the circumstances of the case and may benefit from an early discussion between the pediatrician, social worker, and the Police. Most stable cases are commonly referred to Community CPMEs.

3.11 Community CPMEs: these are available for stable CYP whose assessment is unlikely to require same-day medical investigations’ results. These CPMEs are carried out by paediatricians in the Community; for Enfield, located in Cedar House, St Michaels PCC, EN2 0JB. Typically, the referring social worker would email a completed referral form (appendix I) to northmid.cpmedical@nhs.net, manned by trained admin in weekday working hours. Internal processes are described in a standard operating procedure (SOP) held by the host community health organization. An email response from the doctor on call (or admin team) containing an appointment date/time offer should occur within a few hours, on the same day as the referral. Note that all efforts are made to accommodate same-day appointment requests, but community CPME service is not an emergency service; it operates during the week within working hours.

3.11.1 General points about Community CPMEs: In places where separate community and hospital teams exist, the vast majority of yearly CPME referrals are seen by community team(s). Enfield Community CPME teams are currently seeing about 100 cases a year and growing.

3.11.2 Doctors in community teams can deal with complex cases in well, stable children. Same-day medical test results are not available to Community doctors at the moment. Therefore, any young child (pre-reception and below) with clearly suspicious bruises or marks, and/or unwell or injured in need of treatment or same-day investigations, for any reason, is not a likely community case and should be discussed with hospital teams (2.6).

3.11.3 Professionals should be mindful that, the smaller the child, the greater the risk of internal injury. If potentially unwell, hospital referrals should not be delayed by a referral to Children's Social Care (CSC), as this can be done later by hospital teams, but hospitals are very busy places, so it is still advisable that the **case originator retains the responsibility** of contacting CSC while phoning the local hospital in advance of their referral.

3.11.4 Community CPMEs date and time appointment offers are to be respected if at all possible. Community paediatricians will have set time aside for CPMEs but do not enjoy an unlimited appointments’ repertoire. The referrer is responsible for ensuring consent and stressing the importance of attending CPMEs to parents and guardians, at allocated times. Parental preferences are accommodated, if at all possible, but this is not guaranteed. A leaflet for parents and service users (Appendix I) has been produced to improve communication and

facilitate informed consent. Because of practical delays in transportation, etc., the last weekly slot for receiving a community referral would be Fridays' late afternoon, in such a time that allows the child and guardian(s) to sort out transportation and be at Cedar House by about 15:30 on a Friday evening at the latest. Some cases might be accommodated later than this, but at the discretion of the doctor and subject to individual case requirements.

3.11.5 Safety in Community CPME appointments: security personnel are not available on site in Cedar House. If the referrer considers that there are serious risks of escalating family conflicts or any other factor resulting in a higher-than-normal safety risk for CYP or professionals, this should be discussed with the receiving doctor and admin team at time of referral or communicated soon after in a changing scenario. There might be instances where Police officers might be required to attend, or, exceptionally, where existing safety arrangements mean a CPME is deemed too risky to conduct in the current community setting.

3.11.6 The vast majority of CPMEs run smoothly. There will be immediate verbal feedback to referrer (Police and/or SW) after the CPME, followed by a formal written report a few days after.

3.12 Special categories of pre-verbal children: children with special needs⁵: children with added communication needs could be considered equivalent to pre-verbal (as per observed abilities) so professionals would be expected to follow process for pre-verbal categories. In general, children with added or special needs are particularly vulnerable to abuse, with an overall higher incidence of referrals and NAIs, so referrers should apply targeted professional curiosity and describe ability ranges at the time of referral. Studies of bruising patterns in children with disabilities showed that the dorsum of the feet, thighs, arms, hands, and trunk are sites of bruising which may happen in the course of normal handling, childhood activity and play. However, many of these sites are also associated with abusive injury, and caution should be exercised before accepting such injuries as non-abusive. History from carers may need to be sought within the scope of multi- agency investigations, including careful weighing of obvious persisting and unexplained behaviour changes evident to those most familiar with the child.

4 Age at presentation: able primary school children (4 to 12)

4.1 Primary school children are continuously evolving. As they move up through school, they acquire a better understanding of the world, and their thinking becomes more sophisticated and abstract. Most considerations above also apply here. Risk profiles change but **no age group is risk-free** (for recent cases, SH - and PC - were young toddlers, but ALJ was already over six years old). Any child who is found to be seriously ill or injured must be seen without delay at the nearest Children's Emergency Department via ambulance. Child protection concerns should not delay the referral of a seriously ill schoolchild to acute paediatric services.

4.2 In schoolchildren, allegations become a more common referrals' trigger and should be taken seriously (page 6). There is complex literature in this respect. In practice, for the scope of this document, it is best to accept the premise that CYP rarely "lie", despite what relatives might say, and therefore, any clear allegation must be met with the utmost attention (2.4), including an immediate discussion with the local organization's Children's Safeguarding Lead and/or referral to Children's Social Care (CSC) at the earliest opportunity, under the responsibility of the individual practitioner who was first in receipt of an allegation - or who first became aware of an existing bruise. Allegations open a window into family life. They are crucial because children may have been injured (including small fractures, internal eye and even intra-abdominal injuries) with no evidence of external injury. Any unwell schoolchild should be referred to hospital without delay, as above. For the rest, community CPMEs are usually the most suitable pathway. Allegations should be documented "verbatim" (in the child's own words) and included in the referral alongside all other important information. During first contact outside of health settings, seeing a bruise is not necessary if the allegation is clear, but it might help to ask. Sometimes, professionals try to obtain allegations (i.e., from siblings in the same setting, even family

members). Caution is advised. It might be best to discreetly concentrate on the original allegation only. Weighing potential discrepancies can be time consuming and difficult: schoolchildren may be imprecise in their recollection, as well as siblings, and emotions are often in turmoil. As the day progresses, incentives to hide incidents or chastisement could grow stronger. Older siblings with mobile phones might swiftly “warn” parents or relatives. In no time, an entire family might pull together to confront a situation. This is not only upsetting but also potentially risky for brave schoolchildren who decided to “open up”. Professionals should still act as in 4.2 and discuss the case, while recording all allegations heard within their agency. Even if a subsequent CPME does not find relevant bruises or signs, comprehensive recording still helps; at the very least, it forms the basis for assessing patterns of recurrent incidents in the same family (trajectory) allowing professionals to make better future decisions.

4.3 In cases where the CPME takes place before police input or interview, it is important for the examining paediatrician to hear the voice of the child and to seek sufficient information from professionals, family, and the child, to determine the scope of the examination. Facing an allegation, professionals should avoid curbing the conversation on the grounds that it might damage the integrity of any later interview with the child. Such an approach could inhibit the child and may not be in their best interests. It could also prevent an examination being conducted thoroughly. CYPs and guardians should be made aware from the outset (via signed consent form) that a copy of the CPME report may be provided to the police. The benefit of successful recovery of evidence relating to an alleged offender is likely to outweigh any potential future claim that a subsequent evidential interview was compromised by a conversation between doctor and patient during the examination. It is in the interests of the child to ensure that further examinations are not necessary, if possible. The conversation should be recorded by the examining paediatrician, in their CPME report.

4.4 Professionals should note that, in any case, **the absence of physical signs in a given CPME does not rule out CPA**. The number of bruises children sustain through normal activity increases as they get older, more physically “daring” and mobile (RCPCH Child Protection Evidence Systematic review on Bruising: March 2020). An agency might receive allegations many days after an incident; signs could have faded. Also, chastisement can occur in exposed sites, making the doctor’s assessment less conclusive, in the absence of allegations. Again, CPMEs with non-conclusive findings are still useful in building up patterns of family life, improving accuracy of future decisions.

4.5 Special circumstances: LADO. If the alleged injury occurred at professional care provider settings, against professional care providers, or those whose job titles include working with children, there will need to be consideration as to whether a referral is made to the Local authority designated officer (LADO). This should be discussed with the local lead or safeguarding manager. For Enfield, see contact details of LADO at <https://traded.enfield.gov.uk/news/2020/jun/lado-local-authority-designated-officer>.

4.6 Special circumstances: Electively home educated (EHE) children. Children not physically attending school might have fewer opportunities for routine daily interaction with others, including trained school staff. There might still be regular contact with other professionals via activities not formally within a school setting, including clubs and many other suitable social activities, and surely the vast majority of EHE children are safe from harm. However, in the few cases where a form of abuse or neglect might exist, there are decreased chances of trained professionals detecting it. At time of writing, a series of high-profile cases have prompted authorities to consider legislative changes – see <https://bills.parliament.uk/bills/3756>. This is a changing scenario. At present, Enfield residents who opt to home educate should register with the Local Authority. If, in the context of a community visit, or in child development, or psychology clinics, or if significant bruising is observed in any context, especially a CPME, concerned professionals need to ensure that the child is safeguarded and not at risk of any further harm. Apart from safeguarding steps as in other categories (3.12) professionals should discuss with parents of EHE children that an email to ehe.team@enfield.gov.uk will be sent to make sure child is registered and known by the appropriate agency.

5 **Age at presentation: Young People (12 +)**

5.1 The UN convention on the rights of the child (UNCRC) define a child as “any human being under the age of eighteen, unless, under the Law applicable to the child, majority is attained earlier” (<https://www.unicef.org.uk/what-we-do/un-convention-child-rights/>). This legal definition, useful as it is to determine rights and responsibilities, overlooks significant differences between age groups. Becoming a “young person”, whether shortly before or after (yet another) arbitrary cut-off age of twelve, brings about changes that deserve specific consideration in the context of suspected CPA: the biopsychosocial and body mass changes of adolescence, a new profile of vulnerabilities, the fight for identity, autonomy and peer-groups, risky lifestyles, and, fundamentally, an improved capacity to understand their circumstances in relation to an environment, family, or value-system; to speak up, and to consent independently for medical assessments or interventions, including CPMEs.

5.2 Assessing capacity in a child or young person. For any assessment, investigations or treatments proposed, including CPMEs, professionals must decide whether a child or young person (CYP) has the capacity to consent on their own. Below are general capacity considerations and specific points related to the CPMEs, which differ in some respects from other medical appointments.

5.2.1 The particularities of CPMEs should be discussed with any CYP asked to consent on their own. This should include, at a minimum, a conversation about what a CPME entails, who the report is to be shared with, and what the potential consequences might be. This can be a difficult conversation. Professionals should balance individual situations carefully, centered on the voice, and best interests, of CYP. The chat should be held at the outset, even when capacity can be generally assumed (after 16 years) because it is not independent from the complexity of the intervention proposed, and/or its consequences. The CQC states that the capacity to consent depends more on CYP’s ability to understand and weigh-up options than on their age. It adds that *“to a more limited extent than adults, 16- and 17-year-olds can take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence: a child’s age alone is clearly an unreliable predictor of his or her competence to make decisions”* (see CQC on https://www.cqc.org.uk/sites/default/files/Brief_guide_Capacity_and_consent_in_under_18s_%20v3.pdf). It should be noted that most guidance on consent relates to typical or traditional medical situations (i.e., investigating or treating medical conditions - where adult’s involvement in any CYP decision is still advised) not to the circumstances of suspected child abuse, where assumptions about parents “as suitable agents” (see 10.3.3 below) might no longer hold. In theory, in serious medical illnesses, 16- and 17-year-olds decisions (not to engage) can potentially, in rare circumstances, be overridden by a parent, someone with parental responsibility or a court, because society has an overriding duty to act in the best interests of CYP. This includes *“circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm”*. In practice, it is best to discuss all aspects of CPMEs at the outset and then **let the process be “led” by the YP him-or-herself** in relation to how and to what extent a medical examination is to proceed (see below). Clearly, involving children or YP at all times, in their own care process, is always better (see below).

5.2.2 A YP younger than 16 years may have the capacity to consent, depending on their maturity and ability to understand what is involved. CYP’s maturity and understanding (Gillick-competence) should, once again, be tested against the complexities of CPA and the implications of the decision to be made. The routine assessment of competence in under 16s should be appropriate to the child’s age. For example, routine assessments of competence would not normally be expected in the case of eight and nine-year-olds but could become more common for children aged over 12. To assess whether or not CYP have the capacity to consent, professionals must make sure that all relevant information has been shared; that the purpose of a CPME has been thoroughly discussed, including potential consequences of going - and not going - through it, and that this understanding is checked, perhaps by asking

CYP to briefly recall or explain the main issues back. Professionals should remember that a CYP who has the capacity to consent to straightforward, relatively risk-free interventions may not necessarily have the capacity to consent to complex scenarios involving high risks or serious consequences. A particularly difficult issue is that CPME reports shared with Police and CSC, including body maps or images, could have legal repercussions for someone close to CYP, including family members. This conversation always requires careful balancing in the best interests of CYP, who need help, while at the same time can do without added distress. Precisely because of these complexities, it is best if capacity assessments and relevant conversations are started **early in the process**, involving legal teams, if necessary, before arriving at CPMEs, not left to doctors in last-minute stressful (even “pull out”) situations in healthcare facilities. Lastly, CYP’s capacity to consent can be affected by their physical and emotional development and by changes in their health, so these should also be part of early considerations, balanced against the long-term impact of CPA (see below).

- 5.2.3** In the London Safeguarding Children Procedures¹³ (updated September 2024) a s47 enquiry (Children Act 1989) is required “where a child is suspected to be suffering, or likely to suffer, significant harm”, to enable the local authority to decide whether it should take any action to safeguard and promote the welfare of the child. Social workers and managers decide at what point and whether to seek parental permission to undertake multi-agency checks and when to inform parents, on a case-by-case basis, since there might be reasons not to. A strategy meeting should provide the home Local Authority with the information it needs, assisted by all relevant agencies, to properly assess the case (see also section 7). After a CPME is considered necessary, usually after “immediate protection”¹³ is achieved, CYP with potential capacity to consent, or significantly contribute to the process, independently from parents, should be involved as early as it is safe to do so. In these instances, it might be appropriate to clarify with a YP about unacceptable or “unreasonable punishment” as below.

5.3 Physical Chastisement in CYP. Physical chastisement is often associated with smacking, spanking or hitting. Smacking is defined as “hitting someone forcefully with the flat inside part of your hand, producing a short loud noise, often to punish a child” (Cambridge Dictionary, 2021). As well as smacking, physical punishment can include, but is not limited to, slapping, pinching, pulling, hitting with implements, making someone eat unpleasant substances or enduring stressful positions for long periods (see also section 10.4). It is unlawful for a parent or carer to use physical punishment to discipline their child. Legislation (Offences against the Person Act 186) – outlines ‘*whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapons or instruments*’ and (Children and Young Persons Act 1933) – ‘*any person who has responsibility for any child or young person under the age of sixteen willfully assaults or allows them to unnecessary suffering or injury*’ (Legislation.gov, 2021). Note age cut-off here, of relevance for CSC Legal teams. In practice, in relation to “reasonable punishment”, the Children’s Act states that “*battery of a child cannot be justified on the ground that it constituted reasonable punishment*”. Weighing physical punishment is related to the circumstances of each case containing factors which are for prosecutors to decide. For CPA multiagency work, it is worth mentioning here that any form of physical punishment that leaves a mark (no matter how small) or if the child is hit with a fist/closed hand or an object, is considered ‘unreasonable’, as well as when chastisement or smacking became more than an isolated incident. The precise interpretation of what could be seen as reasonable lies beyond the scope of this protocol. Nevertheless, stakeholders discussing issues with YP would just be need to make them aware that what they are going through is not “normal” and themselves be aware that “any incident that uses enough force to cause visible injury” is consider assault, not reasonable punishment and can result in criminal charges (see NSPCC ending physical punishment on <https://www.nspcc.org.uk/support-us/campaigns/end-physical-punishment/>).

5.4 Please involve the YP early on the process. Capable YP are indeed a different category. Rapport and trust are fundamental. When allegations surface, the best interview with an articulated YP is

obtained before CPMEs, outside of a health setting, unless the YP wishes otherwise. Professionals are advised not to put the YP in a passive role and not to make decisions for them, including attending a CPME altogether. Before referring to CPMEs, YP should be **specifically asked if they want to see a doctor and whether they are willing to show the doctor the injuries or bruises they might have**. YP, with independent access to personal mobile phones, might choose to take a pic of their injuries and take their own phone to a CPME to share them directly to the doctor.

5.5 Let the YP lead the way. Once the YP arrives at a CPME, doctors would also have a chat, assess capacity, establish rapport and seek consent. YP can choose if they wish to proceed with examination alone or accompanied by a relative of their choice. YP should be offered to choose what areas of their body and what bruises or injuries to show the doctor; the doctor following through with examining those and only those, unless the YP changes his or her mind. A female YP should count with a **chaperone** in all cases, especially if the examining doctor is a male, and vice versa. The chaperone's role is to protect YP from abuse, to oversee appropriateness, and also to protect professionals from false allegations. Ideally, the chaperone should be a health professional or have health training, if available, or be trained within a health agency, but should not be party to CSC teams, or a relative. In concerning cases, especially but not limited to those where clear NAIs are found, doctors should consider the safety of any younger sibling(s) and request them to be referred if not already done so. This is usually arranged at the original point of referral.

5.6 Special circumstances: suspected CPA in LACs. Looked after children (LACs) may be seen with bruises or injuries. Although all other considerations above RE bruises still apply, these can be complex cases, and most would benefit from CPME. Here, the **timing** of observations should perhaps be even more carefully recorded, who saw what and where should be immediately documented, and photography by foster carers is advisable if it might help a later assessment by doctors, possibly straight from the FC's device. Any finding should be immediately relayed to the case SW, and consideration given to a CYP physical state prior to any unsupervised contact should be recorded. Case SW would decide at what point to involve parents in shared PR. Allegations from CYP should also be carefully documented by FCs as they happen, and relayed to SW. Thresholds for CPMEs in these cases should be low, unless bruises result from witnessed accidents, and even then, there should be clear documentation in accordance to FC and LAC policies.

5.7 Special circumstances: CPA in Emergency Protection Orders (EPO). As above, if EPO decision is made, it is advisable to document, if at all possible, the physical state of the child(ren) *before physically removing them or shortly after*. If, for any circumstance, a CPME prior to EPO being granted is not feasible, then FCs are asked to document carefully any observed bruises as soon as possible, ideally in the presence of the case SW, or share this ASAP with the case SW. This protects the FC from potential future Court situations where solicitors might argue about timing of bruises, and whether they appeared after the EPO was granted, while under the care of the FC (this actually happened twice in Enfield since 2020).

6 Points about specific injuries

6.1 Fractures

6.1.1 Fractures are usually serious injuries in children, requiring medical input. These would typically be Hospital cases. RCPCH evidence summary⁶ suggests that abusive fractures are more common in children less than 18 months of age than in older age groups; multiple fractures are more suggestive of abuse than non-abuse - except when witnessed accidents occurred (usually road traffic accidents – RTAs); that rib fractures (in the absence of major trauma, birth injury or underlying bone disease) have a high predictive value for abuse; multiple rib fractures are more commonly abusive than non-abusive, and that femoral fractures are more likely to result from abuse in children who are not yet walking.

- 6.1.2** Occasionally, expert consultation is required to determine whether fractures noticed in very young pre-mobile babies are new or resulted from birth trauma. Birth hospital teams would typically document bruises carefully in newborns who experienced a traumatic delivery. Teams might check a Moro reflex for symmetry, and if unclear, they might request early or same-day X-rays. But sometimes, initial Moro reflexes might not entirely reflect some types of underlying long bone fractures, leading to complex situations. The short message here is that these complex cases should be dealt with by experts; the role of primary care and non-health agencies is to exercise professional curiosity and refer if concerned.
- 6.1.3** Hospital trauma specialists would investigate these cases. In the long bone of the arm (the humerus) a type of elbow fracture called “supra condylar humeral” is well-known in children and associated with accidental injury; whilst the commonest abusive humeral fractures in children aged less than five years tend to be other types, called “spiral or oblique” fractures. Humeral fractures in those aged less than 18 months have a stronger association with abuse than humeral fractures in older children. Metaphyseal fractures are more commonly described in physical child abuse than in non-abuse. In the head, linear fractures are the commonest abusive but also non-abusive type of skull fractures. Also, pelvic, hand, feet and sternal fractures can occur in physical abuse and appropriate radiology is required for their detection.

6.2 Burns

- 6.2.1** Burns and scalds are also common injuries, especially in young, mobile children; the majority (≈90%) are accidental - resulting from unintentional injury - with an estimated ≈10% secondary to maltreatment; in these instances, neglect being ten times more common than CPA.
- 6.2.2** Parents usually seek medical attention if they worry that the burn is large, significant or potentially infected, while trying to deal with most small, localized burns by themselves. Small, localized burns may not be seen in any healthcare setting. “Delayed” presentations are therefore a matter of individual consideration.
- 6.2.3** The most common *intentional* burn injury are scalds (hot liquid burns) followed by *contact* burns. Site, location and shape are again important. Abusive scalds most frequently involve immersion injury, with clearly demarcated edges in a glove and stocking distribution or involving buttocks and legs (immersion) and are frequently bilateral and symmetrical. There may be central sparing of the buttocks and of the popliteal fossa.
- 6.2.4** Features of non-intentional (accidental) scalds include irregular margin, asymmetrical and anterior distribution, often anteriorly on infants lying down, or on upwards-facing skin areas in young children where a hot liquid was spilled, in relation to their height, usually from above. Here, it is particularly important to obtain an accurate history (“like watching a movie”) as parents or guardians typically remember these unpleasant episodes well and should, if present, be able to retell them accurately. Potential supervision concerns can be elicited, including potential neglect and the presence of sibling-carers.
- 6.2.5** Scalding involves a hot liquid. In contrast, abusive *contact* burns tend to be found on the trunk, upper arm, thigh and back of the hand. Abusive contact burns are often multiple, in contrast with unintentional burns that are generally single. Abusive contact burns are classically clearly demarcated, of universal depth, and might carry the shape of the hot implement used.
- 6.2.6** The RCPCH published its updated Systematic review on Burns in August 2022⁹. Key findings include abusive burns prevalence estimated to be 5.3%, equivalent to 14% of all children admitted to burns units; highest for those aged less than one year (infants). Children with abusive burns were found to be significantly younger than those with accidental burns. However, amongst all causes of physical abuse, those with burns were significantly older and more likely to be boys.

- 6.2.7** As with bruises, in burns, professionals would contrast a given story against observed developmental ability of the child. Burns in disabled children whose mobility is equivalent to younger age groups are also a cause for concern.

6.3 Abusive head injuries or trauma (AHT)

- 6.3.1** Infants (and young toddlers) with AHT can present with a variety of symptoms, ranging from poor feeding, lethargy, seizures, and respiratory difficulty. Most cases are obviously unwell and need urgent Hospital input. Some might not be acutely ill, presenting, for example, as a BRUE (see point 2.11) or more slowly, as an infant with an unexplained increasing head circumference (OFC). Unexplained growing OFCs over the expected curve lines might be detected in a primary care setting and deserve immediate attention, not only because of the possibility of hidden abuse (leading to subdural blood collections) but also because there are other (medical) causes, all of which serious, of chronic head enlargement, which can lead to permanent disability if untreated.
- 6.3.2** As in point 2.11, the diagnosis of AHT should also be considered in any infant or young child who presents with stopped breathing (apnoea) or BRUE (above) technically defined as an episode in an infant (less than 12 months of age) with a duration of less than one minute and followed by a return to the baseline state, not explained by identifiable medical conditions, and including one or more of: central cyanosis (blue spell) or pallor; absent, decreased or irregular breathing (apnoea), clear change in tone (“went floppy”) and/or altered level of consciousness (“going drowsy”). These, even in the absence of external bruises, can indicate head injury, and are often seen as part of “shaken baby syndrome” which also, amongst other things, can affect the baby’s eyes (retinal haemorrhages). As above, all suspected BRUEs and AHTs are Hospital cases, unsuitable for community CPMEs.

7 The MASH and CSC role in suspected CPA

- 7.1** Children’s Social Care usually takes any MASH referral made under this protocol as requiring consideration for further multi-agency investigation and should check local systems for any risk factors and consider whether a strategy meeting is required to include the consideration of a Child Protection Medical Examination being undertaken.
- 7.2** The decision regarding whether a Section 47 enquiry and a Child Protection Medical Examination (CPME) are undertaken or not should be taken within a Strategy Meeting at which there should be representation from the Police and Health agencies. Inviting other relevant practitioners will depend on individual cases – this may include the practitioner or agency who made the referral, school or nursery, and/or any health or care services the child or family members are currently receiving. If the decision at the Strategy Meeting is that a CPME is not required, the health representative should consider potentially unmet medical or developmental needs of the child and whether a medical assessment is still required, outside of the context of a CPME. If this is considered in the best interests of the child, appropriate referrals can be organized via GP or consulting with DD or DN.
- 7.3** Where there is a risk to the life of a child or the possibility of serious immediate harm, an agency with statutory child protection powers (the police, local authority CSC and the NSPCC) should act quickly to secure the immediate safety of the child¹³. Emergency action may be necessary as soon as the referral is received from a member of the public or from any agency involved with children or parents. Alternatively, the need for emergency action may become apparent only over time as more is learned about a child or adult carer’s circumstances. Neglect, as well as abuse, can pose such a risk of significant harm to a child that urgent protective action might be needed. When considering whether emergency action is required, an agency should always consider whether action is also required to safeguard and promote the welfare of other children in the same household (e.g. siblings), the household of an alleged perpetrator, or elsewhere (see also 10.2 Place of Safety).

7.4 Unless there are exceptional circumstances, a child and family attending a CPME will be accompanied by a representative from Enfield CSC (typically a social worker – SW). It would be good practice for the investigating officer to attend the CPME if at all possible. Ideally, the accompanying SW should be the same leading on the case (assigned) instead of a colleague who perhaps is not fully aware of important details. This is, however, not always possible and doctors would still accommodate changing circumstances to ensure children are seen.

7.5 **Making a referral for Community CPME.** Admin staff man the generic account, during weekly working hours, at northmid.cpmedical@nhs.net where referral emails with attached completed referral forms are received. The email with an attached form constitutes a formal referral for a Community CPME. Referral emails are passed over by dedicated admin to the Rota doctors, usually more than one, to check sooner availability. There are some practical points to consider:

7.5.1 **Information on CPME referral form.** Even if, for time pressures, most elements in the referral form are “copied and pasted” (i.e., from case material written elsewhere) referrers must still ensure that essential information is clear and sufficient, including reasons for CPME, correct dates of (alleged) incidents, complete names *and job titles* (note these are often absent) of all professionals mentioned in the form, alongside complete inclusion, DOBs, and **correct name spelling** of all CYP referred (without which admin cannot retrieve NHS numbers) and of any relevant adults. Recent information is paramount; it is not necessary to include every detail of historical CSC involvement in the form, or a long, copied list. A brief summary should suffice.

7.5.2 Any existing image, voluntarily provided by a CYP or family member, should be included only if compliant with CSC regulations and after obtaining due consent. Otherwise, any relevant photograph taken outside of a CPME context can be shared with the doctor by the CYP or concerned relative directly from the device in which it was taken during the actual CPME. Doctors also have their own way of documenting injuries via photographs or body maps.

7.5.3 Stakeholders (CYP or adults) able to provide relevant information should be present in the CPME. In Enfield, face-to-face conversations are the preferred format. Often, parents or relatives might have the impression they can “dial in” remotely to a CPME. This is strongly discouraged. Furthermore, in the current setting, it is not possible to coordinate three-way telephone or virtual conversations with a parent or carer and a social worker, whose presence in any such conversation would be required. If key stakeholders are not present, the doctor would concentrate on physical examination and provide a report to the best of their knowledge.

8 Documentation in CPA

8.1.1 Contemporaneous, comprehensive, accurate, dated, and timed records should be kept by all agencies. In CPME reports, the mapping, description and recording of the size, colour characteristics, site pattern and number of the bruises, or site and similar descriptive features of the injury, should be made on a body map or diagram. Photographs should be retained as part of the documentary evidence.

8.1.2 Documentation can be crucial in supporting professionals to protect the child from further harm. Practitioners’ documentation may also be used in a subsequent criminal investigation or other court processes.

8.1.3 CPME reports are formally delivered by Community Paediatricians a few days after the CPME itself. Verbal feedback, however, is immediately after a CPME, to relevant parties, to support decision-making. CPME reports have a standard feature, in electronic word format, signed electronically, and any professional involved can request later clarifications if needed. Currently, “paperless” trusts mean little to no use of printed paper, moving all patient records to electronic formats. There might be a place for discussion with CPS in terms of frequent requests from solicitors of “handwritten original forms” which are increasingly in disuse.

Handwritten maps are not, however, and these should be available as part of all CPME reports, except in cases where no injuries are detected, and this is explicitly commented on the main body of the report.

9 Timing of the Child Protection Medical Examination (CPME)

- 9.1** The timing of the CPME should be determined by the circumstances of the case. If a child needs medical treatment without delay (emergencies or urgent care) the procedures to gather and preserve evidence may be carried out at the same time as necessary medical treatment(s), by Hospital teams.
- 9.2** Where a child is brought to hospital by the Police with a suspected non-accidental injury and concerns regarding acute medical needs, examination by hospital pediatrics staff will be performed upon presentation, and in such cases, this examination may be carried out in the presence of a police officer.
- 9.3** The non-urgent (planned) medical assessment of a child with suspected physical abuse (Community CPME) should normally commence as soon as feasible, ideally within 24 hours of referral being registered, but timing should be based on clinical need. In those circumstances where more than 24 hours' gap is anticipated, clear communication between doctors and referrers is expected, so parties are aware of where each party stands, management is not discontinued, and Place of Safety is guaranteed (RCPCH Good practice service delivery standards for the management of children referred for child protection medical assessments: October 2020).
- 9.4** The timing of a planned Child Protection Medical Examination that may have been requested by Children's Services following a joint initial investigation with The Police, may also be affected by the deterioration of potential evidence or by healing processes. In these cases, a conversation between Social Workers, the Paediatrician and Investigating Police Officers will be useful to determine the most suitable timing of, and arrangements for, the Child Protection Medical Examination.

10 General considerations

- 10.1 Language interpretation:** when English is not the main language in a family - in any relevant member whose input might be necessary in a CPME – referrers (SWs) are responsible for booking suitable interpretation. Different settings have different policies. In general, face-to-face interpretation is preferable in CPMEs. Complex communication needs to take place, and this might be unrealistic or impractical via phone or remote interpretation. Contextual language cannot be appropriately gauged. If time is of the essence, remote interpretation might just do - doctors might concentrate on their main task which is a physical examination - but in most cases, it might be preferable to defer a CPME safely (i.e., the following day) if this improves chances of a more meaningful interview via face-to-face interpretation, especially for families where children speak better English than their parents.
- 10.2 Place of safety (PoS):** Place of safety is a crucial consideration for all cases of suspected abuse. This complex decision is best made within a group of experienced professionals, on a case-by-case basis, where age categories (Figure 1) play an important part. For instance, s135 of the Mental health act states that, in law, *"the place of safety to which the (mentally unstable) person is taken can be residential accommodation provided by the Local Social Services Authority, a hospital as defined in the Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place where the occupier is willing to temporarily receive the person"*: see for instance s135(6) of the Mental Health Act at <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2024/05/Londons-Section-136-Pathway-and-Health-Based-Place-of-Safety-Specification-May-2024.pdf>. Outside of MH crises, for children at risk of (further) abuse, PoS can vary from the home of a safe relative to emergency foster placements, often in the context of a Police Protection Order (PPO) or emergency care order - see for instance <https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/>. In the feedback immediately after CPMEs, doctors encountering likely NAIs can contribute to

any necessary deliberation in this respect, but healthcare staff are not responsible for actual placement decisions or their outcomes.

10.3 Section 47 and CPME “thresholds”

10.3.1 A multi-agency assessment should be initiated following referral and should continue whenever a s47 enquiry has commenced.

10.3.2 In the context of a s47 enquiry, a threshold for initiation is when “*there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm in the form of physical, sexual, emotional abuse or neglect*”; following an EPO or when the use of police powers of protection is initiated¹³. Concerns may be apparent early in the process, or might appear later, when more evidence or information surfaces, as these are dynamic processes under uncertainty; s47 conditions would continue whenever the criteria above are satisfied.

10.3.3 Within s47 enquiries, consideration is given to the need for medical treatment or input and who will carry out what actions, when and for what purpose. There are, in this sense, **no separate or fixed thresholds for CPME**, different from the broad ones in 10.3.2, that triggered the enquiry in the first instance. There is no way to know *ex-ante* whether a medical examination will reveal evidence relevant to the case at hand. The decision to refer to CPME rests with a Panel carefully examining evidence and concerns. If in doubt, stakeholders can email DD at a.freiberg@nhs.net, the Named Doctor at c.shankar1@nhs.net or the generic CP inbox northmid.cpmedical@nhs.net for a targeted consultation. At time of writing, phone hotlines are in the process of implementation. Here we discuss some practical considerations:

10.3.3.1 There should be some thinking about how useful a CPME is likely to be for the case at hand. The logistics involved mean CPME referrals should not be “automatic” for all cases. Surely, many are self-explanatory, including, but not necessarily limited to, cases strongly featuring potential CPA (allegations or observed injuries). Here, doctors should promptly examine CYP, check for injuries, provide feedback and/or carry out tests, if necessary. Time and place of CPMEs depends on age of child and whether medically unstable, as discussed above.

10.3.3.2 It is important to put CPMEs in their right place and **not to pivot important safeguarding decisions on them, more than it should be**. Stakeholders may benefit from knowing that, in most cases, not much might be seen by doctors. Many types of abuse have no obvious medical signs. Enfield local data collection since 2020 (when count began) shows that doctors found “*most likely NAIs*” in less than 15% of all CPMEs referred. This is considered relatively high. Anecdotal NAIs “detection rates” in other NCL Boroughs can go from 5 to 15%; but these rates are heavily dependent on the denominator (total number of yearly referrals received) which, in turn, can vary significantly, even between neighboring Boroughs. The causes of such variation remain unclear; thought likely associated with different historical trajectories and/or service configurations. In Enfield Safeguarding Partnership training cycles, it is often emphasized that “doctors are not diviners”. It helps to know that, under uncertainty, doctors face evolving injuries that may not match timing of allegations, or injuries without a history which, by virtue of their location and shape, are virtually undistinguishable from accidental injuries. In other words, the absence of NAIs does not rule out the possibility of (even serious) CPA (see point 4.4).

10.3.3.3 Apart from “self-explanatory” instances, **CPMEs tend to be more useful in situations with at least some degree of complexity**. Experienced professionals in MASH strategy meetings can assess complexity and use their intuition to estimate hidden risks from known risks. In fact, potential complexity is also part of the rationale behind figure 1 (above) and thinking by age groups. Arguably, complexity increases in families with unborn

or young children, especially infants, pre-verbal or young schoolchildren, where allegations might not surface, and coercion is easier. It also increases with suspected multiple substance abuse, sibling-to-sibling or domestic violence, disabled children, acrimonious separations, and/or suspected CSA (CSA is not dealt with in this protocol). Complexity is also a factor in suspected fabricated or induced illnesses (FII), with high extra-familial risk, cumulative concerns, and/or what is called “*organized and complex or institutional abuse*” – see for instance CP8 in London Safeguarding procedures¹³.

10.3.3.4 There are relatively less-complex situations where CPMEs might also be useful. CPMEs without signs can still be useful to inform future case management, help defuse family situations and perhaps even engage families to find a way forward. It is impossible to include all possibilities; professionals are encouraged to gauge issues on a case-by-case basis. One example of a common less-complex scenario involves “acute altercations” between parents and YP (see above) where allegations are met with a corresponding admission, YPs are able to come forward and exercise individual agency, may not be keen to see the paediatrician, and/or where professionals feel a safe way forward is feasible. **The point is that CPMEs should be used wisely.** Using CPMEs as vehicles to address simple, potentially unmet physical or mental health needs is debatable and would depend on doctor’s availability and service configuration. Arguably, most CYP found in a concerning situation (capable of triggering a s47) have the potential to obtain at least some benefit from seeing a doctor or receiving health input. However, unless there is suspected complexity (as in 10.3.3.3) this might not need to be the paediatrician at secondary care level. Judgement is to be exercised. For instance, simple, non-acute, prevalent issues (especially those associated with straightforward deprivation) might be better managed at primary care level, by health professionals (GP or HV) with the capacity for serial follow-up, including (for example) issues like treating lice, or scabies, ensuring input from Healthy Child Programme (HCP) or following growth charts. Again, individual considerations always apply: a young child found wandering the streets alone is not straightforward deprivation and clearly warrants a CPME, even if looking happy and well. The last issue is behavioural or mental health (MH) problems. In general, the younger the child the more inclined towards CPMEs professionals would be. Abnormal behaviour can be a sign of hidden abuse, often serious, in young children, or represent undiagnosed neurodevelopmental disorders which fall under the paediatrician anyhow. In Enfield, Community CPMEs have helped speed up diagnosis of autism (ASD), early developmental impairment (EDI) and/or other disorders or as urgent input in cases where previously unknown autistic children were at risk of harm. Conversely, the value of Community CPMEs might be less clear in YP with longstanding MH issues or neurodevelopmental disorders who might instead benefit from referral, consultation and assessment by CAMHS, unless a crisis team is activated in Hospital circumstances.

10.3.4 If in doubt, a conversation between referrer (usually a SW) and doctors is advisable, either via phone or in writing, via email. This can help clarify some issues or consider others, especially when the received referral form is not sufficiently clear. If needed, paediatricians could also suggest elements of a (future) health plan, as recommended targets for potential future CSC categories (CPP or CIN plans) for health and to address developmental problems or to interpret behavioural problems.

10.4 Working in partnership with parents and carers - cultural competency

10.4.1 Consultations involving children and their parents or carers are known as “tridimensional”. They have three basic elements: the child (or not-Gillick competent YP); parents or guardians, and agency professionals. In most instances (e.g., a medical consultation, school chat, or equivalent) health, education and/or other agencies’ professionals base their communication and actions on the *assumption* that parents or guardians understand and prioritize the best

interests of the child. In other words, society assumes that parents are, by default, “automatic agents”, capable of representing their children’s best interests. In the vast majority of cases this holds true. However, in some cases, parents might truly believe they uphold their children’s best interests while failing to see the world from their perspective. This is often felt most acutely in safeguarding, within contrasting value systems (i.e., from one region of the world to another, or one generation to the next) and in clashing cultural beliefs in relation to how CYP “should be brought up”.

- 10.4.2** These issues, especially in the context of allegations or visible injuries, add extra and sometimes unexpected layers to the above normal relationship between stakeholders: safeguarding concerns challenge the assumption that parents or guardians are indeed acting as suitable agents of their CYP’s best interests.
- 10.4.3 The voice of the child** becomes even more important in situations where appropriate parental agency can no longer be assumed. The NSPCC (May 2024) states that: *“listening to and capturing the voice of the child is essential for effective safeguarding practice. It helps professionals to understand children’s experiences, hear their views about their lives and circumstances, and take effective action to support or safeguard them* (see also page 6 above). The NSPCC also provides excellent case studies for the voice of the child in <https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/voice-child#:~:text=Listening%20to%20and%20capturing%20the,to%20support%20or%20safeguard%20them>.
- 10.4.4** Since partnership with parents or guardians is still the most desirable outcome, as far as possible, parents or carers should be included in the decision-making process, unless to do so would jeopardize information gathering (e.g., information which could be changed or destroyed) or if this open process could pose a further risk to a CYP. It should be explained to parents, at an early stage, why in cases of bruising or suspected NAI in children, additional steps, questioning, and examination might be required.
- 10.4.5** Parents should be given sufficient information and time to understand these new, unexpected situations (CPME leaflet + suitable interpretation). Most families engage. However, if parents or carers become uncooperative or refuse to take the child to booked further assessments, this should be reported immediately to CSC (and/or to referrers). If possible, and especially with younger age groups, the child should be kept under supervision until steps can be taken to secure their safety. Professionals should also consider their own safety at this time.
- 10.4.6** Professionals working in safeguarding frequently come across so-called “cultural” chastisement. The term is controversial; often taken to mean chastisement as a tolerable (and perhaps recommended) method to control undesired behaviours and ensure “correct” upbringing, under certain cultural norms or traditional worldviews which lie outside of UK current context and accepted parameters. Barnet SCP colleagues published a comprehensive review online (see at <https://thebarnetscp.org.uk/bscp/p/professionals/physical-chastisement-statement-guide-for-professionals>). This review defines chastisement and sets out the current legal framework (see section 5 above).
- 10.4.7 Cultural competency is not collusion.** Cultural competency has been defined as the professionals’ ability to understand, deal with, and influence change in *“a wide variety of cultural attitudes to parenting, discipline and the use of physical punishment of children”*; where *“some parents may be unfamiliar - or actively disagree - with [local] legal and moral principles which forbid parents to hit their children”*. Cultural competency implies being aware of, and sensitive to, the cultural practices of diverse North London populations, but it **does not imply any degree of collusion** with oppressive practices disguised or presented as cultural issues. North London migrant families, whether aware or not, might feel dislocated and might

resort to chastisement if they think this eventually stops their children “deviating” from cultural norms and behavioral expectations representing their original value systems¹². Engaging parents from these communities requires effective, plain and simple, cross-cultural communication. Professionals should discuss any perceived cross-cultural issues openly with parents and strive to highlight possible ways forward. In low-complexity CPMEs, a frank conversation with the doctor might increase the chances of parental engagement and therefore of a better family future, with happier children.

10.4.8 Professionals should discuss that **physical punishment has negative long-term effects** on a child’s physical, emotional, and mental wellbeing all the way into adulthood. Physical punishment (including but not limited to smacking, slapping, pushing, or hitting with an implement) causes injuries but also negative long-term feelings of anxiety, isolation, victimization, low self-esteem, and withdrawn behaviour. Contrary to “tempering character” chastisement fosters future risks of anti-social behaviour, aggression between children including fighting and using violence for attention, accepting violence as legitimate tool, and future breakdown in family relationships, including increased violence between parents and children, into adulthood. More reading on this complex, current topic is suggested at https://www.researchgate.net/publication/5551171_Physical_Punishment_Culture_and_Rights_Current_Issues_for_Professionals.

10.5 Notes on parental responsibility (PR).

10.5.1 The GMC elaborates comprehensive guidance (<https://www.gmc-uk.org/professional-standards/the-professional-standards/protecting-children-and-young-people/appendix-1--assessing-the-capacity-of-a-child-or-young-person>) on various safeguarding topics. Here, a ‘person with parental responsibility’ (PR) is “*someone with the rights and responsibilities that parents have in law for their child, including the right to consent to medical treatment for them, up to the age of 18 years in England, Wales and Northern Ireland, and up to 16 years in Scotland. Mothers and married fathers have parental responsibility, and so do unmarried fathers of children registered since 15 April 2002 in Northern Ireland, since 1 December 2003 in England and Wales and since 4 May 2006 in Scotland, as long as the father is named on the child’s birth certificate*”. An unmarried father whose child’s birth was registered before these dates, or afterwards if they are not named on the child’s birth certificate, does not automatically have parental responsibility. He can gain parental responsibility by re-registering a birth, by entering into a parental responsibility agreement with the child’s mother or by getting a parental responsibility order from the courts. Married stepparents and registered civil partners can gain parental responsibility in the same ways. Parents do not lose parental responsibility if they divorce. If a child is taken into local authority care under a care order, their parents share parental responsibility with the local authority. If the child is in voluntary care, the local authority has no parental responsibility. Parents lose parental responsibility if a child is adopted. Parental responsibility can be restricted by a court order. Adoptive parents have parental responsibility, as does a person appointed as a child’s testamentary guardian or special guardian, or a person given a residence order. Local authorities have parental responsibility if there is a care order relating to a child.

10.5.2 In CPME referrals, it is best if PR is determined by the referrer. Determining PR can, especially in safeguarding circumstances, be more complex than it seems. It is recommended, unless urgent medical input is needed, that professionals within CSC (referrers; MASH) check who legally holds PR *while* making a referral for MASH or CPME, taking into consideration who would accompany the CYP to the appointment, consulting their case files or legal teams if necessary. Doctors would check for PR routinely (as signed consent is asked before examinations) but doctors are typically busy, need to concentrate on establishing rapport and on examining children; CPMEs can be fluid, occasionally chaotic situations with unusually complex families with many children (or partners) and various informal arrangements.

Arguably, it is overall safer for the safeguarding system as a whole that PR is checked in advance of a medical appointment and that doctors are informed of the circumstances of the case, in the dedicated section of the referral form.

11 The role of the Police in suspected CPA

- 11.1** Trained Police officers work in partnership with other agencies including Children's Social Care, Health, and Education, in making enquiries to safeguard and secure the welfare of any child within their area. Police have a duty to investigate crime and to bring offenders to justice to ensure positive outcomes for children with the principle that the welfare of the child is paramount.
- 11.2** The Police, on receipt of a referral made under this protocol, will conduct a review to consider the need for any immediate safeguarding measures to be implemented in order to safeguard the child or children involved, taking any referral made under this protocol as requiring further multi-agency investigation.
- 11.3** The Police will notify partner organisations of the referral (if not already aware) and the requirement for a strategy discussion as defined in Working Together 2026.
- 11.4** The Police will actively participate in Strategy Discussions and undertake such actions to ensure the safety of all identified children and if deemed appropriate secure and preserve evidence in accordance with legislation and best practice.

Glossary

Allegations: in the context of injuries, an allegation is a story related to an observed bruise or injury by a concerned party. The weight given to an allegation depends on individual circumstances and the child's age. In general, for non-mobile infants, especially younger than six months, the sole presence of a bruise could be enough to justify further actions, regardless of allegations. Professionals should also enquire about BRUE. As the infant becomes progressively mobile, and thereafter in child protection, obtaining and recording timely, precise allegations is a crucial part of safeguarding. In a sense, a CPME starts not when the doctor sees the child, but at the time of family's first contact with professionals, including calls and home visits. Stories, especially from siblings, are best obtained in their familiar setting. What is alleged should be communicated in detail to other professionals and the receiving medical team. Every effort should be put in obtaining and recording precisely all that is said by any involved party. Without this, further work can be hindered and might result in either too little or too much concern around individual cases.

BONY prominences or protuberances. Areas of the body that "protrude", meaning they are external in relation to other body parts. Genuine accidents tend to cause bruising in exposed areas which, due to our anatomy, come most frequently into contact with hard surfaces. The pre-mobile infant is by definition unlikely to hurt him/herself, even in exposed areas, so this definition does not apply. As motor development progresses, infants slowly acquire more reflexes to protect themselves as they move about, leading to most accidental bruises to be observed in "bony protuberances" including elbows, knees, shins, forehead, and outer parts of forearms. Less frequent (and therefore potentially suspicious) are bruises located on infants' back, ribcage, on abdomen, on lower face, eyes, mouth, or ears, high up in thighs or perineal area, clavicles or shoulders. List is not exhaustive. Mechanism of injury (allegation) must match precisely the bruise seen in the location shown. Single large bruises are also concerning.

BRUE - BRUE (previously ALTE) is defined as an episode in an infant less than 12 months old characterized by: < 1 minute duration (typically 20-30s); followed by return to a healthy baseline state; not explained by identifiable medical conditions, and which includes one or more of the following: Central cyanosis/pallor; Absent, decreased or irregular breathing; Marked change in tone (hyper or hypotonia); Altered level of consciousness. BRUEs would need medical evaluation, and doctors would further stratify the type of event. In terms of safeguarding, professionals should be aware that BRUE can result from infants' maltreatment, including shaking, suffocation, severe neglect and/or exposure to substance abuse.

Bruising: A bruise is a hematoma that forms due to bleeding into subcutaneous tissue, under intact skin, caused by vascular damage or injury. The colour of a bruise is not a reliable indicator of the age of a bruise, and there is a wide variability in the appearance and healing of bruises, both among individuals and among bruises on the same person. (*NICE Clinical Knowledge Summary – Bruising. March 2021*)
NB: It is not possible to age bruises based on their colour.

Mobile infant: An infant who, despite being less than one year of age, is observed to be capable of rolling, sitting, crawling, bottom-shuffling, cruising and/or walking independently. This is a different group from above but is included here because of shared small size / vulnerability / risk of internal injuries and for ease of guidance's age cut-off when motor developmental milestones vary from child to child.

Non- Accidental Injury (NAI): Any inflicted bruise, mark, burn or other injury (i.e., inflicted by anyone for any reason). A variant of NAIs might include wider scenarios where injuries occurred directly from failure to safeguard a child from harm, where that failure has been deemed to reach a threshold for neglect. A "likely NAI" is an injury or group of injuries which are judged by a trained professional to be an unlikely result from the alleged story or accident described to that professional. Hence the importance of obtaining and recording precisely any allegations given by involved parties. **In addition:** any abuse such as a bruise, mark, burn or other injury purposefully inflicted on a person or sustained because of a failure to protect the child from an injury, where that failure reaches a threshold of neglect.

Non-mobile child or young person: A child or young person who for reasons of disability or developmental delay is unable to move independently through crawling, cruising, or bottom shuffling. Particular attention should be given to the risks in those children unable to roll over independently.

Pre-mobile infant: An infant who is not yet crawling, pulling to stand, bottom shuffling, cruising, or walking independently. For the purposes of this protocol, this includes all infants under the age of six months, in addition to those infants 6 months or over who have not yet achieved their first of the above milestones.

References and research findings

1. There is a substantial and well-founded research base on the significance of bruising and injuries in children. The Royal College of Pediatrics and Child Health (RCPCH), in March 2020, has published its updated “Child Protection Evidence Systematic review on Bruising “, which evaluated the scientific literature, published up to January 2019, on abusive and non- abusive bruising in children. [Bruising: systematic review – RCPCH Child Protection Portal](#). This Systematic Review advises within its Key Findings that cases have been reported where bruising was a “sentinel injury” in children prior to the recognition of child abuse, highlighting the importance of exercising professional curiosity in recognizing abnormal characteristics of bruising in children, enabling detection as early as possible and potentially preventing escalation of abuse with avoidance of serious abusive injury or death. This Systematic Review advises that there is no change in the evidence that it is not possible to age a bruise based on a naked eye assessment.
2. Bruising in an infant who is not independently mobile is rare – the study by Kemp et al in 2015 found that on single inspection 93.3 percent of pre-mobile infants do not have a bruise rising to 98.7% in pre-rolling infants. (Kemp AM, Dunstan F, Nuttall D, et al Patterns of bruising in preschool children—a longitudinal study Archives of Disease in Childhood 2015;100:426-431)
3. The RCPCH has also published, in September 2020, its Systematic review on Fractures, which evaluates the literature that has been published up to March 2020 Fractures: systematic review – RCPCH Child Protection Portal. Within this systematic review on fractures, it is noted that fractures found in younger children are often due to abuse, and the studies included in the review state that in children less than one year, 25-56% of all fractures were abusive.
4. Children under the age of two years are at an increased risk of serious physical abuse and are rarely able to contribute to history themselves. (RCPCH Child Protection Companion, Chapter 9: Recognition of Physical Abuse, as updated December 2021). The Triennial Analysis of Serious Case Reviews from 2014 to 2017, published in March 2020, advises that, as in earlier analyses, the largest proportion of incidents relate to the youngest children, with 42% being under 12 months old and 21% being aged 1 to 5 years.
5. It is also recognized that children with disabilities are at increased risk of abuse compared with their non-disabled peers, and that they are less likely to receive the protection and support they need when they have been abused. (NSPCC Deaf and Disabled Children: learning from case reviews Jan 2016). Also, Deaf and disabled children: learning from case reviews | NSPCC Learning (NSPCC Deaf and Disabled Children: learning from case reviews Jan 2016)
6. The radiological investigation of suspected physical abuse in children | The Royal College of Radiologists (rcr.ac.uk) Revised First edition December 2018 and Fractures: systematic review – RCPCH Child Protection Portal RCPCH Child Protection Evidence Systematic review on Fractures: September 2020
7. Patterns of bruising in preschool children--a longitudinal study - PubMed (nih.gov) (Kemp AM, Dunstan F, Nuttall D, et al Patterns of bruising in preschool children—a longitudinal study Archives of Disease in Childhood 2015;100:426-431)
8. Complexity and challenge: a triennial analysis of SCRs 2014-2017 (publishing.service.gov.uk) The Triennial Analysis of Serious Case Reviews from 2014 to 2017, published in March 2020.
9. Burns: systematic review – RCPCH Child Protection Portal RCPCH Child Protection Evidence Systematic review on Burns: August 2022
10. Child protection service delivery standards – (RCPCH Child Protection Portal October 2020)
11. The RCPCH Child Protection Companion, Chapter 9: Recognition of Physical Abuse, as Updated December 2021, notes that Abusive Head Trauma (AHT) is the most common cause of death in physical abuse and is predominantly seen in children less than 2 years of age, most commonly in those less than six months of age.
12. Dinesh Bhugra, Migration, distress and cultural identity, British Medical Bulletin, Volume 69, Issue 1, June 2004, Pages 129–141, <https://doi.org/10.1093/bmb/ldh007>
13. London Safeguarding Children Procedures Manual (section 10 – consent) – see https://www.londonsafeguardingchildrenprocedures.co.uk/chi_prot_enq.html#:~:text=Children%20under%20the%20age%20of,responsibility%20can%20consent%20for%20them.

Child Protection Medical Examinations

Ensuring children's safety and wellbeing are statutory duties of many governmental and professional bodies across the UK. In a given community, some children could be at risk. If no one asked questions, we would never know. Against this background, professionals and families work hard to keep children safe. Facing unclear circumstances, injuries, or bruises, professionals might decide that it is in a child or young person's best interests to be seen by a paediatrician. This type of medical appointment is called a **"child protection medical examination" (CPME)**.

Why does my child need a Child Protection Medical Examination?

There are many reasons why a panel of professionals might worry about bruises or circumstances in or around a family. Every case is different. Often, a simple clarification is all it takes. Attending a CPME does not imply any wrongdoing. The doctor will carry out a typical medical examination and assess any potential health issues and/or signs of abuse. This helps professionals and families understand where support is most needed.

What happens during a Child Protection Medical Examination?

CPMEs are just one of many safeguarding processes we might all be asked to contribute to. A social worker (SW) usually accompanies the family, but, unless parents or young people (YP) wish, is not present during the CPME. Before starting, doctors ask parents – or those with parental responsibility – for informed, written consent. Young people are usually able to consent on their own. Doctors will clarify any doubts, follow children's preferences wherever possible, ensure confidentiality, privacy and modesty, and make sure everyone is as comfortable as possible. To minimize family life disruption, doctors will be as quick and efficient as they can be and accommodate appointment preferences wherever possible. However, the overall situation can still be stressful for parents, children and young people. Families' engagement, attendance and patience with professionals are highly valued, and will be reflected positively in reports.

Your Rights and Responsibilities

During a Child Protection Medical Examination, children, young people, parents and guardians have specific rights to ensure the process is conducted appropriately. Please discuss them with your social worker and/or the doctor:

1. **Consent:** signed, informed consent is gained from the individual or authority that holds parental responsibility (PR) at the time of the CPME, or from a young person (YP) deemed capable – doctors use their own form. Parties can decline at any time during the examination and can ask questions or express concerns freely to their social worker or doctor.
2. **Dignity:** The child's modesty and privacy are respected during the medical examination. Potential sexual abuse and/or its consequences are not routinely assessed by our community services. There are other services specialized in these cases. Please discuss with your Social Worker if concerned.
3. **Confidentiality:** Personal and medical information is only used as required under the GDPR Act 2018 - only essential parties are copied in reports.
4. **Communication support:** Many of our doctors speak other languages, but CPMEs are conducted in English. Please discuss with your social worker beforehand if you think you need an interpreter.
5. **The voice of the child:** children should be comfortable to express concerns. The doctor or SW could propose specific CPME arrangements to ensure your child's voice is heard free from pressure.
6. **The voice of parents:** parents and relatives also have the right for their voices to be heard and included in reports, but we remind all parties that CPMEs are centred on children and young people and should, first and foremost, reflect their needs and concerns **as they see them**.
7. **CPME reports:** Doctors are open to addressing any health query that might arise during the consultation, so please feel free to ask. Doctors also hold rights to a professional opinion; CPME verbal or written feedback might be given to all parties or only to some, at the doctor's discretion.
8. **Conduct during CPMEs:** Safety is paramount. All questions are acceptable, but verbal or physical threats will not be tolerated. We ask parents to kindly clarify any doubts with their SW **before** attending a CPME to avoid later disagreements and to ensure that, once in Cedar House, clinics run smoothly, looking forward to the future and thinking together at how potential issues can be best resolved.