The Royal College of Emergency Medicine

Best Practice Guideline

Paediatric Emergency Medicine
Professional Advisory Group

Detection and Management of Non-Accidental Injury in Infants

Royal College of Emergency Medicine

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Contents

Summary of Recommendations

1. Child safeguarding as an issue and a process should form part of emergency department induction for all clinicians. This should include information about how to detect NAI and who to ask for help.

2. Clinical leaders and managers should aim to provide support from the child safeguarding team 24 hours per day, 7 days per week.

3. Clinical leaders and managers should ensure clear processes are in place to obtain and share information between different agencies.

4. Every effort should be made to ensure that secondary care clinicians can obtain information in a timely way from primary care (for example, the provision of direct access telephone lines that bypass practice switchboards).

5. All infants who present with an injury should be seen by a competent and appropriately experienced clinician and discussed with a senior clinical decision maker before they are discharged.

6. Regular multi-disciplinary meetings should take place to review safeguarding decision making and ensure that decision making thresholds are consistent and appropriate. These meetings may also review recent presentations to hospital and ensure appropriate actions have been taken.

7. Emergency Departments should ensure that the details of how to contact healthcare professionals who are able and available to provide expert advice, help and support are known to staff.

8. EM clinical directors should ensure that pathways exist for the admission and onward specialist assessment of infants in who NAI is suspected.

9. Emergency Departments should have advice leaflets available which explain the child safeguarding process including why it is happening and what to expect.

10. Emergency Departments should use a safeguarding checklist which is specific to infants.

Scope

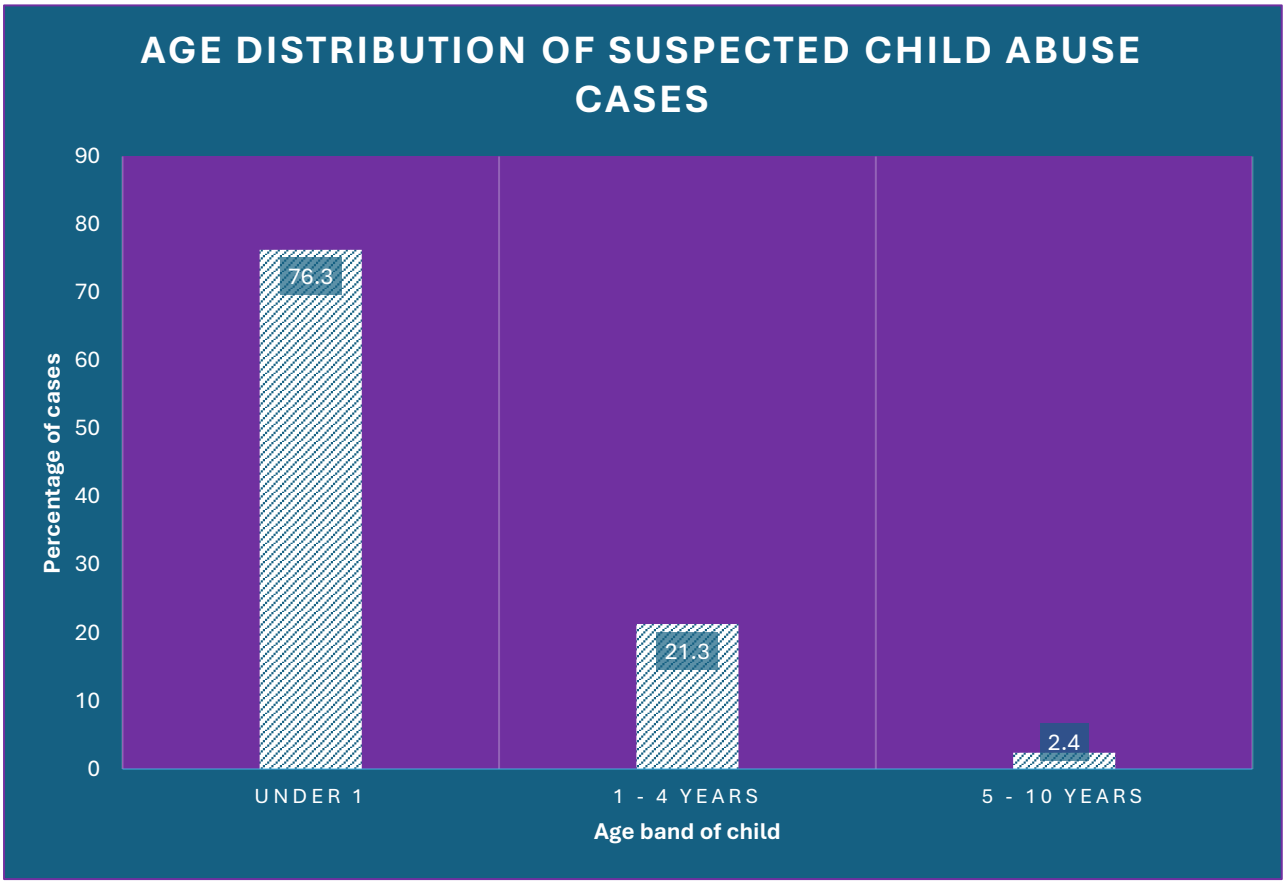
All clinicians who see and assess infants in an emergency or urgent care setting.

Reason for development

Dealing with potential or actual infant non accidental injury (NAI) in the emergency department (ED) is a difficult, complicated, time consuming and a highly emotive area of practice. Understanding the process and getting the ultimate decision-making right for this group of highly vulnerable patients is critical, both for the infant and their family. It is assumed that all clinicians involved with assessing infants for NAI will have undergone appropriate child safeguarding training (Level 3 training). However, the evidence suggests that this does not necessarily fully mitigate the risk of missing infant NAI (HSSIB, 2023) and it remains an area of practice that is challenging, even for the most senior decision makers.

Infants under one year of age is the age group that is most likely to be killed by an adult.

Age Distribution of Suspected Child Abuse Cases



Source: https://emj.bmj.com/content/32/12/921

An infant is five times more likely to be killed than an older child (excepting the higher rates of violent death in later adolescence), with a rate of 28 per million (NSPCC, 2024). From April 2022 to March 2023 the child safeguarding review panel reviewed 393 serious incidents (CSPRP, Child Safeguarding Practice Reveiw Panel, 2022), 36% of which pertained to infants under one year of age (CSPRP, 2024). Infants who die only represent a minority of the total number of cases. Many more infants suffer physical and emotional harm due to abuse. This is sometimes detected but, for every case that is detected, there are likely to be many more that go unrecognised. Infant survivors of childhood abuse are likely to suffer significant harm that profoundly affects their future life chances into adulthood.

In May 2023, the Health Services Safety Investigation Body (HSSIB), undertook an investigation into NAI in infants who had attended the emergency department (HSSIB, 2023). They looked at serious incidents, interviewed experts and talked to staff working on the front line in hospitals. Their report identified room for improvement in the way that NAI is detected and managed. The HSSIB acknowledged the challenges involved, including barriers to obtaining information and involving other professionals, such as paediatric and hospital safeguarding teams. The HSSIB also identified that there was no nationally agreed guidance in this area that was specifically targeted at ED clinicians. They recommended that the RCEM produce guidance to aid clinicians working in this challenging and important area.

This guideline is the response to this recommendation. It aims to give practical advice and a consensus on what is expected from clinicians working in EDs and the system in which they work when assessing and managing actual, or potential, NAI in infants. We understand that the individual clinician can have little control over the wider system in which they work. We have therefore identified key areas for clinical leaders such as Clinical and Medical Directors to focus on, to ensure effective practice and engagement between specialties and other relevant agencies.

Identifying infants presenting with NAI is a challenge when working in the ED, so it is important to have a clear and consistent approach to support the identification of these vulnerable children.

Detecting potential NAI in infants

It is very important that a thorough history is taken and that the infant is subject to a complete external clinical examination. This should include fully undressing all children who present with an injury under the age of 12 months. It is essential that documentation is detailed and accurate with any injuries being carefully described. Documentation from clinician's notes may be required in future court proceedings.

The police utilise the ABC acronym below when investigating a situation where potential NAI is under consideration. It acts as a useful mnemonic to avoid cognitive bias. However, it is equally important for the infant's long-term well-being that these initial consultations are handled sensitively, and that empathy and compassion are applied. Not all cases of suspected NAI will be NAI, and not all the infant's carers will be complicit, or even aware. It is not the task of the examining clinician to identify any perpetrator. Their task is to identify potential NAI from the history and clinical assessment and then implement local safeguarding processes.

A - Assume Nothing. (Don't make assumptions or rush to judgement based on the appearance of carers or background social circumstances)

B- Believe no one. (Don't automatically believe information you are given)

C- Check everything. (Check what you are told with appropriate validation wherever possible)

This is a difficult task which needs to occur in conjunction with an empathetic approach towards carers who have presented with an injured infant, and this balancing act is undoubtedly one of the most challenging tasks in dealing with potential NAI. When taking this approach to accurately gather information, the ED clinician should ask a number of important questions.

Is the proposed mechanism consistent with the observed injury?

Can you visualise what has happened to result in the injury and see how the pattern of injury or bruising has occurred?

Is the mechanism given consistent between different witnesses and does it remain consistent over time. For example, is the explanation of how an injury has occurred consistent between triage and in the clinical assessment. Nursing staff often spend more time with patients and families, and it can be useful to observe how the information given evolves.

At what stage of development is the infant, and is this level of development consistent with the mechanism of injury?

It is essential to be clear on the motor development of the infant. It may be helpful to review the WHO motor development milestones to consider the appropriate motor development stage for the infant you are assessing. A non-mobile baby who cannot roll, crawl, or pull themselves up to sit or stand is not able to injure themselves and is in a high-risk group if they attend ED with an injury. It is important to ask parents what developmental level the infant has reached and then observe the infant to assess whether they can move in the way that relates to the mechanism given. Once an infant becomes mobile, and they can move independently, it becomes possible for them to injure themselves accidentally. However, there is a considerable difference, for example, between an infant (inappropriately, but perhaps not maliciously) left at the edge of a bed who wriggles and slides off the edge, to one where the infant is supposed to have moved from the middle of the bed to then fall off.

Bruising in non-mobile infants

Bruising is the most common finding in infants who present with non-accidental injury. It is reported that it is accidental in only 0 - 1.3% of babies who are non-mobile (CSPRP, Child Safeguarding Practice Reveiw Panel, 2022). Bruising however, is a much more common finding in infants after

they become mobile and much more likely to be caused accidentally. It is therefore very important to carefully consider the possibility of NAI in non-mobile infants who present with any bruising. This does not necessarily mean that all these babies should enter a formal safeguarding investigation, but the context of the injury should be carefully considered. Many localities acknowledge that non-mobile babies are a special group at increased risk and have specific protocols on how this patient group are investigated and managed. Please ensure you are aware of your local policy.

In any infant that presents with bruising, there needs to be consideration of possible medical causes of bruising, such as an undiagnosed coagulation or haematological disorder. This aspect of the clinical picture may need investigation by the inpatient paediatric team in parallel with the safeguarding process.

Are there any risk factors?

Child safeguarding panel reviews, in addition to other sources, have shown an association between NAI and the following risk factors:

- Substance/alcohol misuse within the home
- Mental health issues with an adult carer
- Domestic violence
- Infant known to social services or a looked after child

Sometimes multiple factors are present and increase the possibility of non-accidental injury.

If any of these risk factors are identified, it does not mean that an injury is definitely non-accidental, but it does increase the risk of this being the case and the ED clinician should respond accordingly.

Injuries that may cause concern

NICE guideline CG89 (NICE, 2009) 'Child Maltreatment: When to suspect maltreatment in under 18's' is the most comprehensive piece of guidance available and lists and describes the different types of injury where infant maltreatment should be considered. We would advise clinicians to read and be aware of this guidance.

Below is a list of injuries that should cause concern. This list is not comprehensive but summarises some of the key recommendations from the guidance:

- Bruising in non-mobile infants.
- Bruising on non-bony parts of the body.
- Bruising of similar shape and size.
- Multiple bruises or bruises in clusters.
- Laceration in a non-mobile infant.
- Thermal injury in a non-mobile infant.
- Thermal injury where the mechanism doesn't fit or suggests forced submersion.
- Fractures with no suitable mechanism, especially if multiple fractures or occult fractures, such as rib fractures in infants.
- Intracranial injury.

- Retinal haemorrhages.
- Spinal injury.
- Visceral injury.
- Mouth injury without suitable mechanism.
- Evidence of anal, peri-anal, or genital injury.
- Apparent life-threatening events witnessed by only one carer, particularly if bleeding from the mouth and/or nose.
- If an infant has sustained a significant injury, where neglect has been a significant contributory factor.
- Where interaction between carer and infant, raises concern about the carer's responsiveness to the infants emotional and care needs.
- Where the infant exhibits features consistent with inadequate care provision e.g. dirty and unkempt, or failing to gain weight and develop due to inadequate intake of nutrients.

The RCPCH have also published several documents (RCPCH, n.d.), explaining the evidence for different types of injury that an infant or child may present with. These are also useful for those wishing to understand more about the evidence behind different injuries.

The RCPCH has produced a child safeguarding handbook, but this is only available to members of RCPCH. It may be possible to obtain a copy via a colleague who is a member of RCPCH.

Recommendation: Child safeguarding as an issue and a process should form part of emergency department induction for all clinicians. This should include information about how to detect NAI and who to ask for help.

Information sharing

After an initial clinical history and examination, sharing further information about the infant and the household that they live in will likely be important in making further decisions. When speaking to agencies such as the police or social services, they will need details of the infants' carers and any other adults who reside in the household or have contact with the infant. It is a good idea to obtain names and dates of birth of all these adults from the outset. It is also vital to share information about other children in the home.

Clinicians should be aware of the potential for bias when obtaining information from external agencies. Absence of information from an agency, does not mean that the injury observed has not been caused by non-accidental injury and likewise because a family or child is 'known' to an agency, does not mean that the injury is non-accidental. All information must be interpreted within the overall context of the case.

Agencies who may be contacted to obtain information:

- Hospital child safeguarding teams.
- Social services.
- Health visitor.
- Police.
- Primary care & general practitioner.
- Hospital records.
- Online electronic systems such as Child Safeguarding – Information System (CP-IS).

There can be barriers obtaining information in a timely way from different agencies. This can be a source of frustration and difficulty. The authors find that involving child safeguarding teams can be of significant assistance and they should be contacted early.

There are several pitfalls when gathering information: no one source of information is completely accurate. For example, because an infant hasn't attended the emergency department at one hospital it doesn't mean that they haven't had attendances at another. Online systems such as CP-IS can aid decision making, but it is known that safeguarding information is not always on the system and decision makers have been falsely reassured by an absence of information.

Issues for clinical leaders

In many hospitals, child safeguarding teams only operate 9-5pm Monday-Friday. Many cases present outside of these times when there is no service. Some hospitals have now moved to 24/7 provision and have seen improvements in safeguarding performance. We think it is important for clinical leaders to be involved with the development of improved provision of safeguarding support and advice.

Recommendation: Clinical leaders and managers should aim to provide support from child safeguarding team 24 hours per day, 7 days per week.

Social services can be difficult to contact and there can be long delays with obtaining appropriate information. On occasion, there can be a reluctance of social services to share information with colleagues in health. Clinical leaders should ensure that there are clear lines of communication and standards for information sharing in terms of process and time limits.

Recommendation: Clinical leaders and managers should ensure clear processes are in place to obtain and share information between different agencies.

Contacting general practices can be difficult and time consuming. Ensuring that there is direct access 'bypass' numbers for clinicians to contact GP surgeries can be helpful and avoid long periods of waiting for switchboards.

Recommendation: Every effort should be made to ensure that secondary care clinicians can obtain information in a timely way from primary care (for example, the provision of direct access telephone lines that bypass practice switchboards).

Decision making and thresholds for when to act

Deciding when to act is difficult and is best done in consultation with senior experienced decision makers. In some departments all infants under one year of age are reviewed by a consultant (or ST4 or above when a consultant is not on site) prior to discharge. We acknowledge that other departments will choose to have different criteria for review prior to discharge. We would recommend that the scenario where junior and inexperienced clinicians are expected to discharge infants with an injury, without clinical review by a more experienced clinician should be avoided.

Recommendation: all infants who present with an injury should be seen by a competent and appropriately experienced clinician[1] and discussed with a senior clinical decision[2] maker before they are discharged.

The possible outcomes are:

- No action.
- Further discussion with another professional.
- Completing a multi-agency reporting form (notification of concern form).
- Reporting to social services.
- Reporting to the Police.
- Admission to hospital as place of safety or for senior/multi agency review.

It is important that the thresholds for taking further action are considered, as with other medical conditions as under investigation and over investigation both have the potential to cause harm.

The authors suggest the following thresholds for acting:

Action	**Threshold**
No action	Seen by an experienced clinician[1] who is very confident that it is not NAI and case discussed with a senior clinical decision maker prior to discharge.
Further discussion (see below for further advice on who to discuss with)	Clinicians are concerned but unsure of what further action to take.
Completing a multi-agency referral form	If there is concern that the infant has sustained non accidental injury or there are concerns about supervision or the environment the infant is cared for in.
Reporting to social services	If there is a significant concern that the infant has sustained non accidental injury.
Admission to hospital	If you believe that the infant needs a place of safety

Reporting to the Police	If the infant is believed to be at imminent or immediate risk of harm, such as if a carer has left the department with the infant against medical advice.
Admission for senior review/multi agency review	This may be appropriate if there is not a senior decision maker[2] available. (For example, a non-mobile baby presenting to a hospital with an injury in the middle of the night).

Note: [1] 'Experienced clinician'; requiring access to on-site supervision but able to see patients independently within an agreed scope of practice e.g. early career specialty doctors, more experienced locally employed doctors. [2] 'Senior Clinical Decision maker'; Senior doctors able to lead a department with remote support. Possess some extended skills that can be practiced independently. Full scope of practice.

Recommendation: Regular multi-disciplinary meetings should take place to review safeguarding decision making and ensure that decision making thresholds are consistent and appropriate. These meetings may also review recent presentations to hospital and ensure appropriate actions have been taken.

Discussion of cases with other professionals

Making decisions in infant safeguarding cases can be complex and difficult. Discussion with other professionals is a good way of sense checking decision making and getting things right. Appropriate people to discuss cases with might be:

- Senior ED clinical staff, especially those with an interest in PEM.
- Senior ED paediatric nursing staff.
- Child safeguarding teams.
- Consultant Paediatrician.
- Community Paediatrician.
- Social Worker.
- Named/designated doctor or nurse.

Recommendation: Ensure that the details of how to contact these professionals is available and known to staff and that staff are able to obtain help and support.

Escalating concerns in the case of differences in professional opinion

On occasion there may be differences in opinion on the best course of action to take between professionals. In these cases, it is advised that the case is escalated and that there is communication between senior members of the safeguarding team, managers within social services and senior clinicians, so that the decision making can be reviewed and it is ensured that appropriate actions have been taken. In the case of differences in opinion on whether an infant should be admitted overnight for senior review in the morning, it is best if a formal agreement/pathway is in place. In

some hospitals, a pathway details in which cases an infant should be admitted and detail that non-consultant grade doctors cannot refuse the admission. If a pathway does not currently exist, then clinical directors should strongly consider negotiating an infant safeguarding pathway and putting this into practice. Emphasis should also be placed on the importance of stating your opinion with reasoning in the notes, even if there has been disagreement with others.

Recommendation: EM clinical directors should ensure that pathways exist for the admission and onward specialist assessment of infants in who NAI is suspected.

Informing parents/carers of the infant safeguarding process

It is understandably difficult for clinicians and carers to discuss the investigation process that is needed to reach a point where NAI is confirmed or excluded. We advise being open and honest with parents/carers explaining what is happening and why it needs to happen. In some hospitals an information leaflet is used to aid this process. Not discussing the process is likely to lead to increased animosity and difficulty maintaining co-operation. In most cases parents/carers understand why this process needs to occur and whilst they often become upset, will comply with requests. On occasion parents/carers and the extended family may become aggressive and / or refuse to co-operate and leave the hospital. In this circumstance, social services should be informed, and the police contacted.

Recommendation: Emergency Departments should have advice leaflets available which explain the child safeguarding process, including why it is happening and what to expect.

Summary

The detection and management of infant safeguarding in the emergency care environment is difficult and challenging. A clear and consistent approach to support decision making is key. It is important to carefully gather key information and take a detailed approach in considering the nature and circumstances of the injury. There are multiple sources of additional information and other professionals to discuss cases with. With careful discussion and consideration, the likelihood of taking appropriate decisions and actions will be increased. This difficult area of practice should always involve senior decision makers in the ED. There are several actions that can be taken by clinical and medical directors that can make the infant safeguarding process more efficient and more likely to lead to appropriate decisions and outcomes.

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Conflicts of interest

All authors are members of the RCEM Paediatric Emergency Medicine – Professional Advisory Group, no other conflicts of interest are declared.

Audit Recommendations

- 95% of children under one year presenting with injury have an infant specific NAI check list completed.
- 90% of children under one presenting with injury are physically reviewed by a competent and appropriately experienced clinician prior to discharge.

Keywords for Search

- Non accidental injury (NAI)
- Infant
- Bruising

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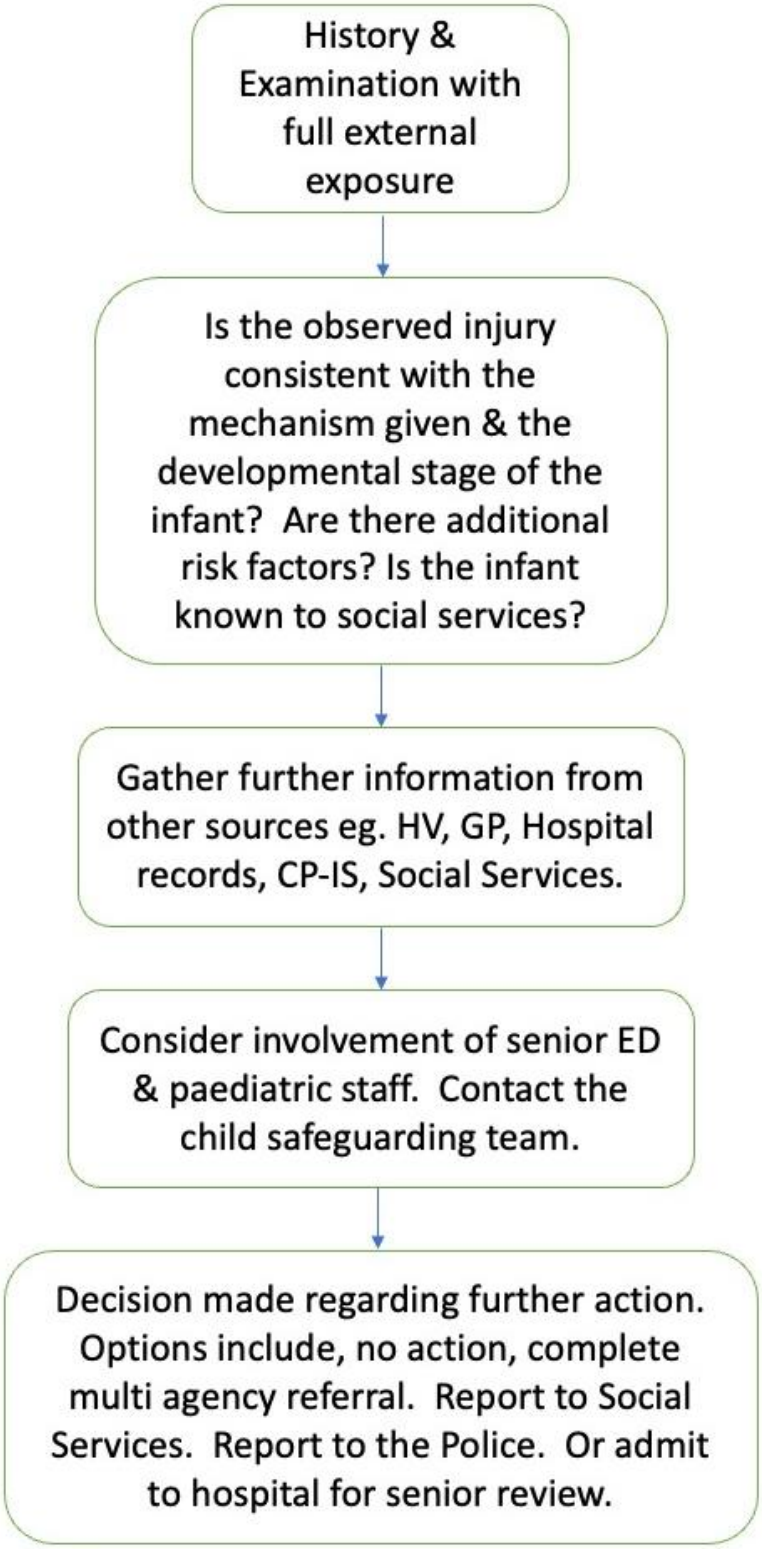
Appendix 1. Summary Infant Safeguarding Process



Appendix 2. Checklist for infant safeguarding procedure

1. Is the mechanism consistent with the observed injury? YES/**NO**
2. Is the mechanism/injury consistent with the developmental stage of the infant? YES/**NO**
3. Is the infant able to move independently (roll, crawl, stand, walk)? YES/**NO**
4. Is the infant known to social services? **YES**/NO
5. Are there additional risk factors (mental health issue in carer, drug alcohol abuse in household, known domestic violence in household)? **YES**/NO
6. Is there clinician or nursing staff concern regarding the presentation? **YES**/NO

If any **bold** responses to this checklist, then case should be escalated. The route of escalation will depend on local policy. This could include escalation to ed consultant, paediatric consultant & child safeguarding teams.

Appendix 3. Useful sources of information

- WHO motor development milestones

- e-learning for health, level 3 child protection training

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