**Teesside procedure for management of non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks presenting to emergency services.**

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**Teesside procedure for management of non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks**

# Scope of guidance

This procedure should be followed by all health professionals who assess non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks across Teesside.

The procedure has been written and reviewed by a multi-agency group chaired by Dr Rosemary Thwaites, Designated Doctor for Safeguarding Children (Tees).

It is due for review in September 2026.

# Definitions

**Non-mobile baby:** A non-mobile baby is a baby who cannot roll independently. This will include most babies under the age of six months.

**Non-independently mobile infant, child or young person:**

A non-independently mobile infant, child or young person is a child who is not yet able to walk independently. It is based on developmental rather than chronological age. It includes babies who are actively rolling, crawling, pulling to stand or cruising and older children who are not able to walk independently, including children and young people with a disability.

# Introduction

Injuries in non-mobile babies are unusual and highly suggestive of a non-accidental cause. Non-mobile babies cannot cause injuries to themselves and therefore must be considered to be at significant risk of abuse if presenting with an injury.

Non-mobile babies with injuries may present to any healthcare setting across Teesside and a unified, consistent approach to these injuries should be taken.

It is also vital that a robust, consistent process is followed for non-independently mobile infants, children and young people who present with injuries. Whilst the likelihood of an injury having a legitimate, accidental cause in these children is slightly greater than in a non-mobile baby, the likelihood of a non-accidental injury remains high and must be considered.

Injuries in non-mobile and non-independently mobile children must never be interpreted in isolation and must always be assessed in the context of a medical and social history and the child’s developmental stage. Any suggested explanations offered by the parents or carers must be fully explored and appropriately questioned with a high degree of professional curiosity. If an accidental injury has occurred, the history is usually very clear and the parent or carer presents to a healthcare professional quickly. Even injuries that are accidental may have safeguarding concerns in relation to supervision, for example, or mitigations may need to be put in place to prevent further injuries to this or other children.

Partnership working between all healthcare agencies, social care and, if required, police is key.

# National context

Severe child abuse is 6 times more common in babies aged under 1 year than in older children. Infants under the age of one are more at risk of being killed at the hands of another person (usually a carer) than any other age group of children in England and Wales1.

35% of serious incidents reported to national child safeguarding practice review involve serious harm to babies, the vast majority physical injury or death1.

Local and national child safeguarding practice reviews have shown that babies are often seen by healthcare providers in the weeks leading up to abusive head trauma or serious injury. Staff in these cases have sometimes underestimated the significance of the presence of bruising or minor injuries in children who are not independently mobile2. They have therefore not considered what appears to be a rather minor injury as an indicator or precursor to significant injuries or death of a child. Early recognition and action in such cases is key to preventing further injuries.

Infants may also present to healthcare providers with non-specific symptoms, increased crying, vomiting, increased head circumference as well as bruises prior to diagnosis of non-accidental head injury3,4. It is important that healthcare professionals ensure babies are fully assessed taking a holistic approach to the whole family to recognise significant occult injury and ensure appropriate safeguards are put in place to reduce risk of injury or further injury in those with minor or sentinel injuries.

Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission. These minor injuries are referred to as sentinel injuries5,6

# Risk factors for abusive head trauma and serious injury

Studies have showed that there are several risk factors that increase children’s risk of suffering abusive head trauma and serious injury. These include:

* Previous presentations with poor weight gain, bruising, fractures, repeated vomiting with no fever, increased head circumference
* Two peaks of age at presentation at 3 months and between 5 and 7 months
* Teenage mother, prior child protection investigation in the family, (regardless of outcome), low birth weight
* Domestic abuse
* Parental mental health difficulties
* Parental substance misuse
* Parents who are care leavers or looked after with little family support.
* Concealed or denied pregnancy

It is important that healthcare staff seeing infants with injuries are aware of and understand these risk factors in the wider context of the presentation and impact on parenting at different stages of a child’s life. Earlier recognition and support for families that may be struggling will potentially reduce devastating injuries and numbers of children removed from parents care permanently.

Although these factors above are associated with increased risk of non-accidental injuries, they can occur in families without any apparent risk factors which is why this procedure must be applied to all appropriate children.

# Sentinel injuries

A sentinel injury is a visible or detectable minor injury in a pre-cruising child that is poorly explained and, therefore, suspicious for physical abuse. These include bruises, subconjunctival haemorrhages, and intra-oral injuries. Practitioners must be vigilant when a bruise or any intraoral bleeding is identified in an infant because these may be 'warning injuries' for possible abuse.

These present an opportunity to intervene and protect children from future harm. In cases of significant non-accidental injuries in infants, up to 30% have previously attended a healthcare setting with a sentinel injuries5.

# Overarching principles for non-mobile babies and non-independently mobile infants, children and young people presenting to healthcare settings

Accidental injuries in non-mobile babies and non-independently mobile infants, children and young people are rare and the threshold for a paediatric assessment must be low. As part of the information-gathering process background information must be sought from social care in all children, even in the rare circumstance that an accidental injury is considered likely. The need for a multi-agency strategy meeting must be considered in all cases.

The decision that an injury is accidental must be made by appropriately trained, experienced clinician following the pathways outlined in this document.

On occasion, children may present to healthcare settings with a history of an accident but no apparent injury. The decision that there is **no injury** must only be made by a suitably qualified practitioner after a full examination of the child has occurred. If the practitioner is confident that there is no injury, this should be documented fully in the child’s notes and the child can be discharged with suitable safety netting advice. In these circumstances, it is not necessary to follow all of the steps in this pathway as no injury has occurred.

If there is any doubt about the presence of an injury, the child should be referred to hospital for further assessment.

# NHS 111

The first point of contact for a non-mobile baby or non-independently mobile baby, child or young person with a possible or confirmed injury may be NHS 111.

The health advisor should complete screening questions and if the infant appears unwell with a potential injury, a 999 ambulance should be dispatched according to standard procedure.

If the patient does not require a 999 ambulance, the health advisor should advise that the patient is taken to the appropriate emergency department. The health advisor should call the emergency department reception to advise that a non-mobile/non-independently mobile patient with a potential injury has been directed to ED. The reception should confirm the patient’s name, NHS number and demographic details, parent/carers’ names and contact details, mode of transport, estimated time of arrival and any known safeguarding concerns. The health advisor should then complete a written referral to social care (SAFER referral) and also phone social care if the referral is urgent.

The reception staff should then inform the clinical team of the patient’s impending arrival.

Each ED must have a process to ensure that the patient has attended in a suitable time frame. They must also have a process to review at the end of each shift that all expected patients have attended.

If the patient is not brought within the expected time frame, the ED team must attempt to contact the family and ascertain their whereabouts and expected time of arrival.

If the family do not attend, or are not contactable, the ED clinical staff must complete a written referral to social care and must contact social care by telephone. The ED consultant must also be made aware.

A summary of this process is shown in appendix 1.

# Urgent treatment centres (UTC)

As accidental injuries in this age group are rare, the threshold for a paediatric assessment is low and a multiagency strategy must be considered.

All non-mobile babies presenting to a UTC with injuries must be referred to the paediatric or emergency medicine teams at your local hospital. **They should not be discharged from the UTC.**

**I**f you are unsure whether a patient is truly non-mobile, it is safest to assume they are and to refer for further assessment.

Patients that require further management of their injuries should be referred to the emergency department. Patients that do not require further management of their injuries should be referred to the paediatric team. In hours, the referred should speak to the appropriate consultant. Out of hours, it may be appropriate to speak to the registrar. This is summarised in appendix 2.

When making a referral to a specialty team the following information should be handed over:

* Mechanism of injury
* Site of injury
* Who was with child at the time of injury
* Who has accompanied patient to UTC
* Are any risk factors present?
* Is the patient already known to social services and is there a child protection plan in place?
* Are there any other children at home or potentially at risk?
* Examination findings
* Treatment that has been received at the UTC
* Has a social services referral been made?
* Estimated time of arrival

If you have any concerns regarding non-accidental injury, then a referral to social services should be made by UTC staff. This should be made by telephone call followed up by a written SAFER form. The refer should make clear their concerns and actions healthcare expect from referral.

If a referral to social care is made, then the decision of how to transfer the child should be decided with social worker in MACH/CHUB or EDT.

**Transport from UTC to hospital**

The mode of transport required to take the patient from the UTC to hospital will depend on the severity of injury and the level of concern regarding non-accidental injury. The decision tool in appendix 3 should be used to guide this decision.

As mentioned above, if a referral has been made to social care then this can be discussed/decided during the strategy meeting.

If a social care referral is not required then a decision regarding the method of transport can be made after discussion with the specialty team the patient has been referred to. The ultimate decision lies with the UTC team that has assessed the patient.

Prior to leaving the UTC the receiving team must be made aware of the method of transport taken, have a contact number for the patient, and an estimated time of arrival. If the plan was for the patient to travel via parents’ own transport, but has not attended hospital, then it is the responsibility of the referring team at the UTC to investigate this further and notify relevant parties.

If the patient has not arrived after what is deemed a reasonable amount of time (this will depend on the individual clinical circumstances and estimated time given) then the receiving team at the hospital will first try to call the parents or carer. If they are unable to contact the parents or carer, then the referral team at the UTC should be informed. It will then be their responsibility to take any further action – this would mean referral to social care is indicated if not already done.

In the event that the patient has not arrived at hospital and the receiving team has been unable to contact the parent/carer but the UTC has closed then it is the responsibility of the receiving team to take any further actioned deemed necessary.

# Emergency department: Non-MOBILE babies with injuries

The flow chart in appendix 4 should be followed for all non-mobile babies presenting to the emergency department with an injury.

A non-mobile baby is a baby who cannot roll independently. This will include most babies under the age of six months. Please note that if a baby is reported to have ’rolled’ from an object in the process of falling (eg falling off a bed rather than rolling themselves), they are still be classed as non-mobile and this pathway should be followed. For any child who can roll but who is not yet independently walking, please refer to section 12.

* 1. **Initial assessment**

The initial assessment of the baby can be performed by any appropriate ED practitioner. This practitioner should take a full history from the parent or carer. The names and relationship of any accompanying adults must be documented in full in the medical notes. The practitioner should perform a full examination of the baby with clear documentation of all findings in the medical notes. Any injuries should be managed appropriately with specialty input as required.

This practitioner must display a high degree of professional curiosity in relation to any alleged accidental mechanisms. Extreme caution must be exercised in relation to vague mechanisms of injury such as tight clothing or straps from car seats, for example. These should not be considered suitable explanations for injuries and any such babies should be referred to the paediatric team for further assessment.

If this practitioner has any safeguarding concerns, including any suggestion that the injury could be non-accidental, the baby must be referred to the paediatric team and a referral to social care (including a written SAFER referral) must be made.

* 1. **Safeguarding risk factors**

If the initial assessing practitioner does not have any safeguarding concerns, they should then assess if there are any safeguarding risk factors present. If the answer to **ANY** of the questions below is **YES**, the baby must be referred to the paediatric team and a referral to social care (including a written SAFER referral) must be made:

* **All staff**. Do any staff who have cared for the baby in ED, including health care and nursing staff, have any safeguarding concerns in relation to the baby’s presentation?
* **Delay**. Was there any unreasonable delay in the child attending the emergency department?
* **Multiple injuries**. Is there more than one injury? This includes the presence of more than one bruise.
* **Fracture or burn**. Is the injury a fracture or burn?
* **Witnessed event**. Is there no clear description of a suitable, appropriate witnessed event that is rich in detail? Is the practitioner unable to obtain a clear account from a definite witness?
* **Development**. Is the injury not consistent with the child’s developmental age? Any developmental milestones reported should be confirmed whilst the child is in ED.

If the answer is no to all the safeguarding risk factor questions above, the ED practitioner can progress to the next step.

* 1. **Face-to-face ED consultant assessment**

The information obtained by the initial practitioner should be discussed with supervising ED consultant. This ED consultant must then examine the baby face-to-face and document this examination in the medical notes.  
  
If there are any safeguarding concerns following this assessment, the baby must be referred to paediatrics and a referral to social care (including a written SAFER referral) must be made.

* 1. **Uncertainty**

Following the face-to-face ED consultant assessment, if there are no clear safeguarding concerns but there is uncertainty about the diagnosis a referral to the paediatric team should be made. Input from other specialists may be required at this stage. An example might include uncertainty about whether a mark is a birth mark or an injury.

A referral to social care does not need to be made at this stage unless it is felt to be appropriate.

* 1. **Vulnerability**

If there are no identified safeguarding concerns, the ED clinician (consultant or other practitioner) should identify whether there are any vulnerability factors present.

A sensitive, open and honest discussion should be undertaken with the parent or carer. In addition, this information must be corroborated by contacting children’s social care using the process outlined in appendix 5.

The vulnerability questions relate to all adults in the household or any other adults known to be in regular contact with the child.

If the answer is yes to any vulnerability question, the baby should be referred to the paediatric team for further assessment. A referral to social care does not need to be made at this time unless it is felt appropriate to do so.

* Overnight presentation. Has the baby presented between 2130 and 0800? It is very rare for babies to present with injuries overnight. If they do, they should be admitted under paediatrics for observation until the morning. This should be explained to the parents or carers. The reason for doing so is to allow a suitable period of observation, to enable consultant paediatric review and to ensure information can be obtained from social care appropriately.
* Is the baby subject to a child protection plan, a child in need or a looked after child?
* Is there any history of domestic abuse?
* Is there any history of mental health difficulties in any adults known to be in regular contact with the child?
* Is there any history of mental health difficulties in any adults known to be in regular contact with the baby?
* Are the parents or carers themselves subject to a child protection plan or looked after/children in care?
* Do you have any concerns about appropriate supervision? Please note this should be considered in all patients, even if the injury is felt to be accidental.

If the answer is no to all of the vulnerability questions, the ED team can progress to the next step.

* 1. **Consultant to consultant discussion**

If there are still no safeguarding concerns, and no vulnerabilities identified, the ED consultant should discuss the baby’s injury and their opinion of the likely causation with a paediatric consultant. This discussion should outline the answers to all of the assessments above and the nature of the injury sustained.

If there is any uncertainty about the injury or about any potential safeguarding concerns at this stage, the paediatric consultant should arrange for the baby to be seen by the paediatric team.

If there are no concerns identified, and there is no requirement for a paediatric assessment, the ED team can move to the next stage.

* 1. **Discharge**

If all of the above processes have been completed thoroughly, there should now be a clear, consistent, appropriate and witnessed account of an accidental injury that has occurred and there should be no outstanding safeguarding concerns.

If there are no on-going concerns, the baby can safely be discharged with appropriate safety net advice and follow up as required. A detailed letter, outlining the answers to all of the safeguarding risk factor and vulnerability questions should be sent to the GP and health visitor. Any need for support or follow up from primary care services should be documented. This will also enable the health visiting team to cross check the answers to all of the safeguarding risk factor and vulnerability questions against their own information.

On receipt of this notification, the health visitor will review the family’s record according to the significant event policy and will consider an extra visit to the family home. If the health visitor has any concerns regarding safeguarding issues, they should complete a SAFER referral and contact the safeguarding team at the respective Trust.

# Emergency department: Non-INDEPENDENTLY mobile infant, children and young people with injuries

The flow chart in appendix 6 should be followed for all non-independently mobile infants, children and young people presenting to the emergency department with an injury.

A non-INDEPENDENTLY mobile infant, child or young person who is not able to walk independently. It is based on developmental rather than chronological age. It includes babies who are actively rolling, crawling, bottom shuffling, pulling to stand or cruising and older children who are not able to walk independently, including children and young people with a disability. For babies who are not yet mobile please refer to section 11.

* 1. **Initial assessment**

The initial assessment of the child can be performed by any appropriate ED practitioner. This practitioner should take a full history from the parent or carer (and child if able). The names and relationship of any accompanying adults must be documented in full in the medical notes. The practitioner should perform a full examination of the child with clear documentation of all findings in the medical notes. Any injuries should be managed appropriately with specialty input as required.

This practitioner must display a high degree of professional curiosity in relation to any alleged accidental mechanisms.

If this practitioner has any safeguarding concerns, including any suggestion that the injury could be non-accidental, the child must be referred to the paediatric team and a referral to social care (including a written SAFER referral) must be made.

* 1. **Safeguarding risk factors**

If the initial assessing practitioner does not have any safeguarding concerns, they should then assess if there are any safeguarding risk factors present. If the answer to ANY of the questions below is YES, the baby must be referred to the paediatric team and a referral to social care (including a written SAFER referral) must be made:

* **All staff**. Do any staff who have cared for the baby in ED, including health care and nursing staff, have any safeguarding concerns in relation to the child’s presentation?
* **Delay**. Was there any unreasonable delay in the child attending the emergency department?
* **Multiple injuries**. Is there more than one injury? This includes the presence of more than one bruise.
* **Witnessed event**. Is there no clear description of a suitable, appropriate witnessed event that is rich in detail? Is the practitioner unable to obtain a clear account from a definite witness?
* **Development**. Is the injury not consistent with the child’s developmental age? Any developmental milestones reported should be confirmed whilst the child is in ED.

If the answer is no to all the safeguarding risk factor questions above, the ED practitioner can progress to the next step.

* 1. **Discussion with ED consultant**

The information obtained by the initial practitioner should be discussed with supervising ED consultant. This ED consultant may choose to assess the child themselves if appropriate.  
  
If there are any safeguarding concerns following this assessment, the child must be referred to paediatrics and a referral to social care (including a written SAFER referral) must be made.

* 1. **Vulnerability**

If there are no identified safeguarding concerns, the ED clinician (consultant or other practitioner) should identify whether there are any vulnerability factors present.

A sensitive, open and honest discussion should be undertaken with the parent or carer (and/or child if appropriate). In addition, this information must be corroborated by contacting children’s social care using the process outlined in appendix 5.

The vulnerability questions relate to all adults in the household, or any other adults known to be in regular contact with the child.

If the answer is yes to any vulnerability question, the child should be referred to the paediatric team for further assessment. A referral to social care does not need to be made at this time unless it is felt appropriate to do so.

* Is the baby subject to a child protection plan, a child in need or a looked after child?
* Is there any history of domestic abuse?
* Is there any history of mental health difficulties in any adults known to be in regular contact with the child?
* Is there any history of mental health difficulties in any adults known to be in regular contact with the baby?
* Are the parents or carers themselves subject to a child protection plan or looked after/children in care?
* Do you have any concerns about appropriate supervision of the child? Please note this should be considered in all patients, even if the injury is felt to be accidental. This includes most fractures and burns in children of this age.

If the answer is no to all of the vulnerability questions, the ED team can progress to the next step.

* 1. **Non-accidental**

If there are still no safeguarding concerns, and no vulnerabilities identified, the ED practitioner should ensure that they are confident that there is no possibility that this could be a non-accidental injury and should document this in the notes. If there is any uncertainty about the injury, the child should be referred to paediatrics for assessment with input from other specialists as required.

If there are no concerns identified, and there is no requirement for a paediatric assessment, the ED team can move to the next stage.

* 1. **Discharge**

If all of the above processes have been completed thoroughly, there should now be a clear, consistent, appropriate and witnessed account of an accidental injury that has occurred and there should be no outstanding safeguarding concerns.

If there are no on-going concerns, the child can safely be discharged with appropriate safety net advice and follow up as required. A detailed letter, outlining the answers to all of the safeguarding risk factor and vulnerability questions should be sent to the GP and health visitor. Any need for support or follow up from primary care services should be documented. This will also enable the health visiting team to cross check the answers to all of the safeguarding risk factor and vulnerability questions against their own information.

On receipt of this notification, the health visitor will review the family’s record according to the significant event policy and will consider an extra visit to the family home. If the health visitor has any concerns regarding safeguarding issues, they should complete a SAFER referral and contact the safeguarding team at the respective Trust.

# Paediatric assessment

**Children referred for paediatric assessment with safeguarding concerns.**

Non-mobile babies and non-independently mobile infants, children and young people may be referred to the paediatric team by other healthcare professionals who have already identified that there are possible safeguarding concerns. The referring healthcare professional should have already referred the child to social care and submitted a written SAFER referral. The paediatric team should clarify that this has occurred.

The paediatric team should ensure that any injuries are appropriately managed with input from ED and other specialty teams as required.

The paediatric team are responsible for performing a holistic assessment of the child, including a full examination and documentation of any injuries. The Trust child protection medical assessment proforma should be used to ensure that this is completed fully. If not already done so, the paediatric team should establish if there are any safeguarding risk factors or vulnerabilities as outlined in sections 11 and 12 above.

The parents or carers should be fully informed of this process with consent to be obtained according to Trust guidance. The child may be assessed by a tier 2 (registrar or ST3+) paediatric doctor initially, however, a paediatric consultant must also assess the child during their admission. The paediatric consultant must personally review any injuries present.

The paediatric team, under the leadership of the consultant, should organise any necessary investigations and further opinions that are required and should follow Trust and national guidance in relation to safeguarding processes. They should discuss with social care about appropriate supervision arrangements whilst the child is in hospital.

A strategy meeting should be held prior to the child being discharged from hospital. A summary of the outcome of this meeting should be documented in the child’s notes.

Where necessary, the paediatric consultant is responsible for writing a child protection medical report with their opinion as to the likelihood of non-accidental injury.

**Children referred for paediatric assessment due to uncertainty, the presence of vulnerabilities or for further assessment**

Non-mobile babies and non-independently mobile infants, children and young people may be referred to the paediatric team for further assessment regardless of whether there are definite safeguarding concerns identified by the referring clinician. This includes any children where there are vulnerabilities identified as outlined in sections 11 and 12.

The paediatric team are responsible for performing a holistic assessment of the child and for identifying any safeguarding risk factors or vulnerabilities if this has not already occurred. Referrals to other specialists for assessment should be made as appropriate.

The paediatric team should consider whether there is any possibility that there could be a non-accidental cause for the injury or any on-going safeguarding concerns. If so, a referral to social care (including a written SAFER referral) should be made and further safeguarding processes should be followed.

The child must be assessed by a tier 2 (registrar or ST3+) paediatric doctor. There should be a documented discussion with a paediatric consultant prior to the child being discharged. If there is any uncertainty, or if there are any potential safeguarding concerns, the paediatric consultant must also perform a face-to-face assessment.

If there is a clear and consistent accidental explanation for the injury, or if the initial concerns are not felt to be caused by an injury (eg a birth mark), the child can be discharged as outlined in sections 11 and 12 above.

# Multi-agency actions to be taken if there are concerns regarding non-accidental injury

If there are any concerns regarding non-accidental injury, all agencies must take steps to safeguard the child and to submit a SAFER referral requesting a strategy meeting.

A telephone strategy discussion may be held in the first instance but must include all three statutory agencies (social care, police and health). The consultant paediatrician should be invited to this strategy discussion, even out of hours.

A consultant paediatrician must see and examine any non-mobile or non-independently mobile child in whom there are concerns about possible non-accidental injury. A written report should be provided for social care, regardless of outcome. The outcome of the medical assessment together with the need for follow up and any necessary actions should be clear. An interim child protection medical report should be given to social care (and police) pending the full report.

As soon as it is apparent that there is a potential non-accidental injury, arrangements should be made by social care to protect the child and any siblings from potential further harm. This will involve immediate supervision of the child. If the child is in hospital and supervision is not available, the parents may be asked to leave the hospital following a multi-agency discussion.

The social worker or health professional must report to police without delay where there isa concern about a child’s welfare that constitutes or may constitute a criminal offence.

The referring professional should be informed of the outcome of any decisions taken. Nursing staff in hospital must inform and update the safeguarding children’s team who can then aid liaison with relevant professionals.

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