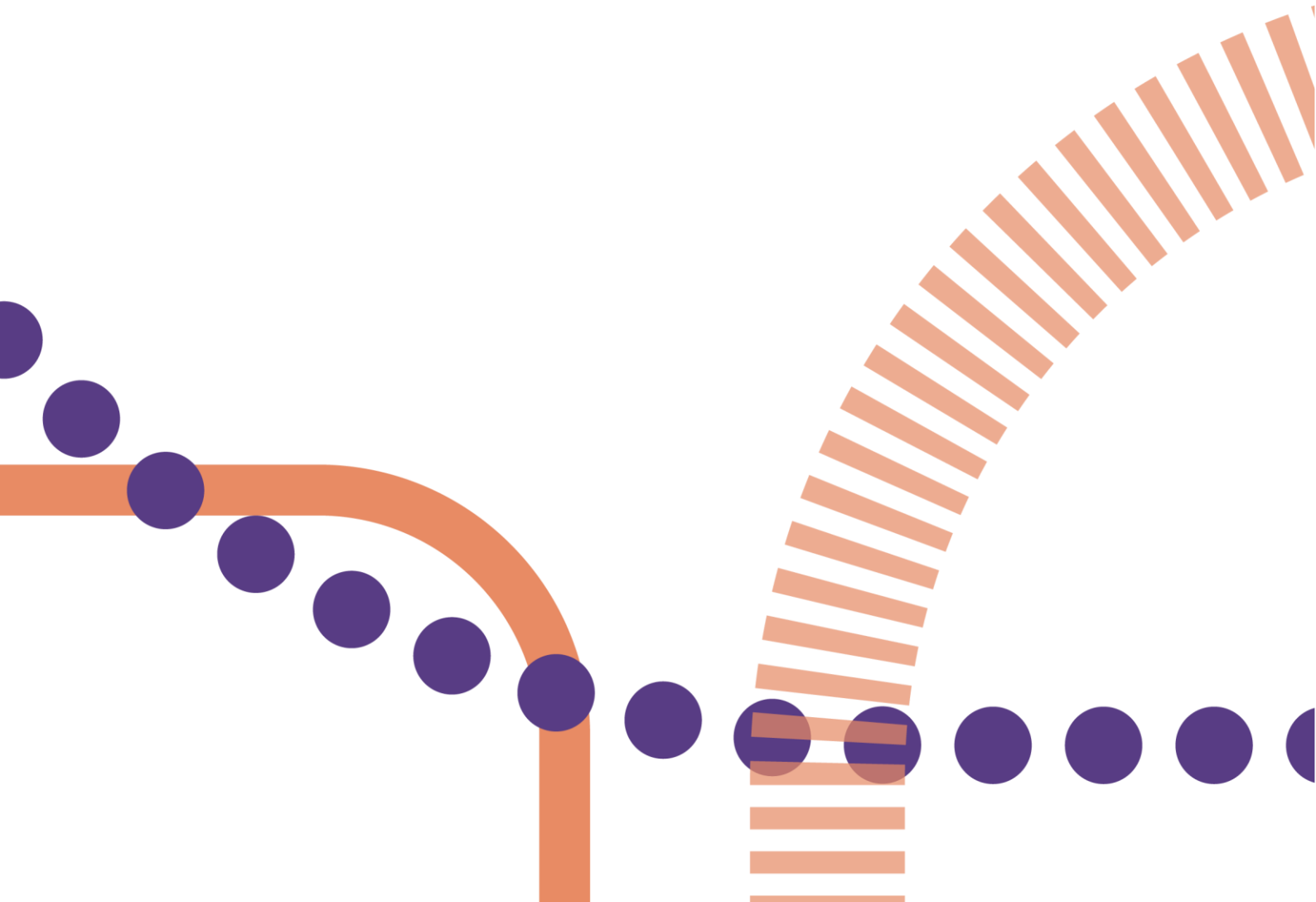
THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Safeguarding vulnerable under 1s

Bruising in non-mobile babies

March 2026



Introduction

The Child Safeguarding Practice Review Panel (the Panel) published a report about the management of bruising in non-mobile infants in September 2022. Evidence shows that bruising is the most common injury in children who have been abused. While children also sustain bruises accidentally, the report concludes that accidental bruising is uncommon in a baby who is not independently mobile, particularly in those who are younger, unable to roll and unable to crawl, and it should warrant careful consideration by safeguarding professionals.

The Panel's data indicates that 36% of serious incident notifications are about children under 1 year old and this age group experiences the highest fatality rate (Annual Report 2023/24). In recent years, the Panel has identified multiple notifications where minor bruising to a child under 1 preceded the incident that triggered the notification. Learning from these incidents highlighted that safeguarding protocols either did not reflect best evidence or were inconsistently applied.

This briefing aims to provide professionals across all agencies with up-to-date, evidence-based practice about safeguarding non-mobile infants.

Who is this document for?

This document is intended for all health professionals, particularly those working in Emergency Departments, Urgent Care Centres, walk-in centres, and GP surgeries, as well as for police officers, children's social care staff, nursery workers, child minders, family hubs and family centres.

How to use this resource

Safeguarding partners and practitioners can use this resource to help guide their local responses when assessing bruising in non-mobile infants. The document summarises current research, national guidance and key safeguarding actions, helping practitioners identify when bruising is a cause for concern.

The aim is to support decision-making by outlining the importance of a medical assessment by an appropriately skilled professional, followed by a multi-agency discussion that considers the child's developmental stage, family context and any known risks.

This resource is not prescriptive; it is designed to complement local policies and national guidance, helping practitioners and leaders to adapt approaches to the realities of family life and reduce preventable harm.

Why is it important for children and young people?

Developing and using effective protocols for the management of bruising in non-mobile infants is crucial for identifying risks early and addressing them through coordinated, multi-agency support.

What is the evidence base?

Evidence from the Royal College of Paediatrics and Child Health (RCPCH) suggests that while bruising can be an indicator of abuse across all age groups, children also sustain bruises accidentally. The exception to this is non-mobile infants, where accidental bruising is rare, occurring in only 0–1.3% of cases.

NICE guidance CG89 (updated December 2025) states*: "Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable."* For the reasons outlined above, bruising in a non-mobile child strongly suggests that any explanation may be unsuitable and should be taken seriously.

Safeguarding partners need to have a clear protocol on the management of bruising in non-mobile babies that is reflected in all local and agency-specific policies. This protocol should define what "not being independently mobile" means, using the RCPCH and NICE definitions, and should state that in all cases of bruising in children who are not independently mobile, the following actions must be taken:

- a review by a medical professional with appropriate expertise to assess the nature and presentation of the bruise, any associated injuries, and the circumstances of the presentation, including the child's developmental stage and any evidence of a medical condition that could have caused or contributed to the bruising;

- a multi-agency discussion to consider any other information about the child and family, any known risks, and to jointly decide whether a referral for further assessment, investigation, or action is needed to support the family or protect the child. This multi-agency discussion should always include the medical professional who reviewed the child.

Finally, safeguarding partners should regularly audit compliance with this practice, together with training and supervision compliance data, to ensure that protocols are consistently applied.

Key facts and figures

The Panel received 133 rapid reviews for children under one year of age between 1 April 2024 and 30 September 2025. Of these reviews, 56 referenced non-accidental injury (NAI), and 27 of those also noted visible bruising.

Domestic abuse was identified in around half of all NAI incidents for under one's. Panel findings also highlight that risk factors—such as parental experience of care, probation involvement, and previous convictions—were often known but not effectively mitigated, pointing to missed opportunities for early intervention and escalation before significant harm occurred.

Factors for effective practice

- **Professional Curiosity & Documentation:** Maintain professional curiosity and ensure thorough documentation of domestic abuse and substance misuse during both pre-birth and post-birth planning.

- **Family Identification & Dynamics:** Identify all adults around the child, record their names, and use **genograms** to understand family dynamics including new partners.

- **Mental Health Considerations:** Consider the mental health of adults in the child's environment. Ensure that practitioners in all agencies ask: *"How do these mental health difficulties impact upon parenting capacity and the daily lives of the children?"*

- **Think Family Approach:** Address lack of joined-up thinking between mental health services, probation, adult services, and children's social care by adopting a Think Family approach.

- **Monitoring Engagement & Escalation:** Monitor and document engagement with multi agency services closely. Where engagement is limited, avoid closing cases to **Early Help** or **Child in Need (CIN)** plans without wider multi-disciplinary discussion and agreement. Revisit thresholds and consider **escalation** to ensure child safety.

Hallmarks of good practice

Strategic & Multi-Agency Collaboration

- **Joined-up strategic planning**: Involve not just core agencies but all relevant partners, for example probation, housing and substance misuse services.
- **Dynamic escalation**: Respond quickly and proactively when concerns arise—babies are highly vulnerable, so systems must be anticipatory and responsive.
- **Early years alert systems**: Ensure nurseries and early years settings are informed of safeguarding concerns and plans for newly registered children to enable multi-agency decision-making. This information will need to be updated as required.

Practitioner-Level Actions

- **Health visitors and domestic abuse**: Create opportunities to speak to mothers alone; if not possible initially, follow up with further contacts. Ensure responses are documented and shared appropriately with partners.
- **Contextual risk assessment**: Consider potential negative impacts on children when individuals who cause harm through domestic abuse are restricted from contact or access to the home.

- **Access to historical records or records held by other local authorities**: Systems should ensure practitioners can request and review previous records to ensure that risk assessments are up to date.
- **Use of genograms**: Employ genograms to map family relationships and dynamics.

Child-Centred Safeguarding

- **Tailored safe sleeping guidance**: Communicate safe sleeping policies adapted to individual family circumstances.
- **Consider compounding vulnerabilities**: Assess contextual factors that increase risk for babies (e.g., parental mental health, housing instability). Draw upon health colleagues to ensure health conditions and particular medical vulnerabilities (e.g. prematurity, complex medication regimes, long term conditions) are well understood by agencies involved in supporting the family.

Leadership & Quality Assurance

- **Toolkit evaluation**: Senior leaders should review single- and multi-agency toolkits used for work with families with babies and young children to ensure effectiveness and consistency.

Reflective questions and discussion points

Information sharing

- Are systems in place to ensure practitioners request and access previous records so there are no gaps in safeguarding?
- Are mechanisms in place to alert nurseries or early years settings about existing safeguarding concerns and plans for newly registered children?
- How effectively are senior managers facilitating information sharing across wider agencies? Could this be strengthened through joint commissioning arrangements?

Practice challenges

- What are the main barriers to information gathering and sharing within and between agencies? How can these be addressed?
- Is there a clear, consistent policy across all departments and agencies for assessing bruising in non-mobile babies?

Family context

- How well are practitioners identifying family stressors and responding to them as part of safeguarding vulnerable babies?
- Are contextual factors that compound vulnerability considered (e.g., housing, mental health, domestic abuse)?

Questions for leaders

- How do current systems support joined-up multi-agency planning for vulnerable babies?
- Are there gaps in escalation processes when concerns arise? How can these be made more dynamic and anticipatory?
- Are supervisors asking the right questions during oversight meetings? What reflective prompts could improve the quality of supervision?
- How can managers ensure reflective practice is embedded in operational decision-making for safeguarding partners and practitioners?

Case study 1

During a new birth visit health visitors identified unexplained bruising and weight loss in a 12-day-old infant. A hospital assessment confirmed traumatic brain injury and a fracture, raising concerns of non-accidental injury. A Police investigation was commenced with supervised contact restrictions in place.

Learning points:

- There were multiple pre-birth assessment gaps, including a previous history of assault on the mother not being known, the father's vulnerabilities not being considered and a personal advisor not being included in pre-birth planning.
- The family found it difficult to engage with the pre-birth plan and this was managed as a child-in-need without checking the lead professional's capacity.
- There were missed safeguarding opportunities. There was no maternity service discharge planning meeting and no strategy meeting, despite extended family raising concerns about father's mental health and substance misuse. A cannabis smell was noted in the home but not explored further.
- Pre-birth plans require clear accountability and effective handover, particularly when families move areas.

Case study 2

A baby died unexpectedly at home while in the care of his parents, after being placed to sleep in a Moses basket. Initial observations suggested a sudden unexpected death; however, post-mortem findings identified intracranial and spinal bleeding and internal bruising, prompting further investigation. The father had a known history of causing significant harm to another child, for which he was subject to probation at the time.

Learning points:

- There was known history of agency involvement in the family in relation to the mother's children from a previous relationship, but this did not inform safeguarding decisions.
- Pre-birth planning was not undertaken and actions from previous plans for the siblings were incomplete.
- Bruising in non-mobile baby procedures were not followed by children's social care or health professionals when bruising on a sibling was noted by the Emergency Department.
- Contextual risks, such as the father's history of poor mental health and probation involvement, were not fully considered.

Overall, both case studies highlighted recurring themes that limited how effectively agencies protected children. Important information about parental history, previous incidents and risk indicators was often missing or not shared, preventing professionals from forming a full picture of risk.

Multi-agency planning was inconsistent. Agencies did not always coordinate actions, attend key meetings or establish clear roles, which meant growing concerns were not addressed in a timely way.

Professional challenge was another gap. Explanations for injuries or concerning behaviour were not always questioned, and escalation did not happen when risks increased. In some cases, lead professionals lacked the oversight or capacity needed for complex situations.

The learning is clear. Stronger multi-agency coordination is crucial, including convening strategy meetings when risks escalate. Professionals should be confident in challenging explanations that do not adequately account for risk and should address all indicators, including substance misuse. Effective information sharing remains essential. Previous safeguarding concerns, including those relating to siblings, must be considered to support accurate assessments.

Where can I find out more?

Find more information on the Panel's new learning hub www.childsafeguarding.independent-panel.uk, where you can access videos, webinars, podcasts and other content.

Other useful resources include:

- RCPCH Child Protection Systematic Review on Bruising
- Foundations, Thriving Babies: Confident Parents
- Foundations, Working with male carers to reduce non-accidental injury to infants under 1 year old
- HSIB, Investigation Report: Non-Accidental Injuries in Infants Attending ED

.