Aug 2026

# LSCP Multiagency Protocol: managing suspicions of physical abuse for children and non-mobile infants

## Contents

## Version Control

| Date Issued | Version | Summary of changes | Approved by |
|---|---|---|---|
| 13 Aug 26 | V1 | New protocol. | LSCP Executive Board |

Date for review: August 2029

# 1. Introduction

## 1.1 Purpose of this protocol

This Protocol outlines the pathways that all practitioners and individual agencies who work with children and families are expected to follow when physical abuse concerns are identified. It provides practical support and guidance to help them discharge their safeguarding duties outlined within Working Together to Safeguard Children.[1]

## 1.2 Who is this protocol for?

This Protocol applies to everyone working with children and their families living in, or looked after by, Lambeth. By children we mean any individual under the age of 18.

# 2. What is physical abuse?

This section summarises what we mean by physical abuse and the various forms it can take. Physical abuse is defined as:

> A form of abuse which may involve hitting, shaking, throwing, poisoning, burning, or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

## 2.1 Non-accidental injuries

Non-accidental injuries are injuries that are suspected or proven to have been inflicted upon a child by someone else, or in the care of someone else. Any bruising, fractures, bleeding, and any other injuries (such as burns) should be treated as a matter for enquiry and potential abuse considered, unless otherwise evidenced.

## 2.2 Bruising

Bruising is both the most common accidental injury a child can sustain *and* the most common injury seen in children who have been physically abused. Bruising can also be the result of children experiencing other forms of abuse such as neglect or sexual abuse. It is therefore vital to differentiate between accidental and non-accidental bruises.

[1] The March 2026 version is in force at time of ratification of this Protocol

### 2.2A Bruising in non-mobile children

Bruising is strongly related to mobility. A child is considered independently mobile if they can do any of the following:

- Crawl
- Bottom shuffle
- Pull themself into a standing position using an object, for example, furniture
- Move into a standing position unaided
- Cruise (that is, move from place to place holding onto an object, for example, furniture)
- Climb, for example onto furniture or stairs
- Walk using a push-along walker
- Walk unaided

Bruising in children who are not independently mobile ('non-mobile') is unusual and should prompt suspicion of abuse. Particular attention should be given to the risks in those children who are unable to roll over.

## 2.3 Otherwise causing physical harm to a child

Physical abuse does not necessarily involve physically touching a child. Physical harm can be caused in other ways, for example:

- Fabricating or inducing an illness in a child
- Causing accidental ingestion of prescribed medication or illicit drugs through neglect
- Through forced exercise or stress positions

This is not an exhaustive list but illustrative of the fact that harm can be inflicted without physical touch.

# 3. Indicators that should raise concern

This section explores the indicators that should prompt practitioners to consider whether further action is required under this protocol. It is aligned with:

- London Safeguarding Children Procedures, PG5. Bruising
- NICE Clinical Guidance, Child maltreatment: when to suspect maltreatment in under 18s

Agencies must ensure that all practitioners receive sufficient training to enable them to identify physical abuse indicators. Indicators include (but are not limited to) bruising, visible marks/injuries and disclosures.

## 3.1 Bruises

A bruise should never be interpreted in isolation. It must always be assessed in the context of medical and social history, developmental stage, explanation given and – where appropriate – full clinical examination and relevant investigations.

The characteristics of bruising that are suggestive of physical abuse and should give cause for concern are:

- Bruising in children who are not independently mobile (including children with disabilities) – see Section 2.2A
- Bruising in babies (even small injuries may be significant, and also might be a sign that another hidden injury is already present)
- Bruises that are seen away from bony prominences (i.e. bruises to soft parts of the body like the abdomen, back and buttocks)
- Bruises to the face, back, abdomen, arms, buttocks, genitalia, ears, neck, and hands: the head is the commonest site of bruising in child abuse
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of an implement and/or a ligature
- Bruises with petechiae (tiny dots of blood under the skin) around them
- Genital or anal bruising.

The following are bruises that can be seen from accidental injuries in mobile children and are not automatically concerning (but should still be considered in the wider context of the child, e.g. level of supervision and plausibility of explanations)

- Bruises to the front of the shin / knees
- Bruises to the forehead (especially when children are learning to walk)
- Bruises to the back of the head in toddlers (who are more likely to fall backwards when trying to walk).

You cannot age bruises through visual inspection, therefore the colour of the bruise cannot be used to assist with making determinations about the time when an injury happened.

## 3.2 Other visible physical injuries

Other visible physical injuries that should prompt concern include:

- Bruised lip or torn frenulum (small area of skin between the inside of the upper and lower lip and gum)
- Cuts (lacerations), abrasions, scratches or scars
- Burns or scalds
- Pain, tenderness or failing to use an arm or leg which may indicate an underlying fracture
- Small bleeds into the whites of the eyes or other eye injuries
- Bite marks, whether animal or human

These must be considered in the context of medical and social history, developmental stage, explanation given and – where appropriate – full clinical examination and relevant investigations.

## 3.3 Disclosures

When children disclose physical abuse, this needs to be taken seriously regardless of whether or not there is any visible injury. It is for social services and, where appropriate, the police to investigate these disclosures.

Practitioners who receive these disclosures need to explore the context and only get sufficient detail to inform next steps (e.g. relevant risk factors, such as a risk to siblings). It is important that practitioners only use open questions (i.e. avoid leading questions where a child can give only a yes/no answer). Please see Section 4.2 for detail about helpful context to inform a social care referral.

Practitioners who receive these disclosures should aim to, as much as possible, ensure records reflect the child's own words and include observations as to how the child presented when making the disclosure (e.g. emotional presentation and demeanour). Although infrequent, it is important to remember that these records may be used as evidence if criminal justice proceedings are later instigated.

It is also important to avoid asking the child to repeat their disclosure to other people in your agency, once a disclosure has been made this needs to be reported as per Section 4 to enable statutory safeguarding responses. If a child has disclosed to more than one person, it is important that records clearly state who the child has spoken to and what they have said on each occasion.

# 4. Required actions when concerned about physical abuse

Please refer to both this flowchart and further, more detailed, guidance below:

Child observed to have a bruise/mark/injury where there are concerns it may be non-accidental (including disclosures/allegations by the child) and/or child discloses physical abuse.

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Does the child have any obvious life-threatening injuries or significant injury?

**Y** → Call 999 (if not already in hospital). Provide first aid to the best of your abilities and training. Once an ambulance has been requested, **make an urgent referral to Lambeth Children's Social Care**.

**N** ↓

Has a non-mobile child sustained a bruise/mark/injury?

**Y** → **Make an urgent referral to Lambeth Children's Social Care**:

1) Call 0207 926 3100 (Mon-Fri 9am-5pm) or 0207 926 5555 (Mon-Fri 5pm-9am, weekends and bank holidays) immediately.
2) **Confirm the immediate plan for the child** (i.e. are they safe to be allowed home with their parent or guardian).
3) Agree what information can be shared with parents/carers and who will share it.
4) Follow up with a written referral on the same working day

**N** ↓

Is there a bruise/mark/injury which is suspected to be non-accidental or unexplained?

**Y** → (see above)

**N** ↓

Has a child made a disclosure that they have been hit with an implement and/or sustained a recent non-accidental injury?

**Y** → (see above)

**N** ↓

Do you believe it is safe for the child to go home?

**N** → (see above)

**Y** ↓

All other suspicions of physical abuse must be referred to Lambeth Children's Social Care by completing a written referral on the same working day that the concern is identified.

## 4.1 Referring to Lambeth Children's Services

All concerns that a child might have been physically abused must be referred to Lambeth Children's Services using the written referral form. However, some concerns require an enhanced and more urgent response. We use the terms '*standard referral*' and '*urgent referral*' to differentiate between the level of required response.

## 4.2 Standard referrals

Written referrals must be made on the same working day and should include:

- Date/time the concern was identified
- Date, time, location and alleged perpetrator of suspected harm (where known)
- Any similar history or risk factors
- What has been reported by the child and parent/carer (using the child's own words as much as possible)
- Indicate where the bruising/marks/injuries have been observed/reported on the body using the body map form (photographs should **only** be taken by the police clinicians / medical photography departments acting on clinician's instructions)
- Detail of the bruising/mark/injury, including (where known):
    - Exact site of injury on the body, e.g. upper outer arm/left cheek
    - Size of injury - in appropriate centimetres or inches
    - Approximate shape of injury, e.g. round/square or straight line
    - Colour of injury - if more than one colour, say so
    - Is the skin broken?
    - Is there any swelling at the site of the injury, or elsewhere?
    - Is there a scab/any blistering/any bleeding?
    - Is the injury clean or is there grit/fluff etc.?
    - Is mobility restricted as a result of the injury?
    - Does the site of the injury feel hot?
    - Does the child feel hot?
    - Does the child feel pain?
    - Has the child's body shape changed/are they holding themselves differently?
- Whether the child has any special educational needs or disabilities.

## 4.3 Urgent referrals

Urgent referrals require additional and more immediate action. Practitioners must:

1) Call Lambeth Children's Social Care to report and provide as much detail about the concern as possible:
    - 0207 926 3100 (Mon-Fri 9am-5pm)
    - 0207 926 5555 (Mon-Fri 5pm-9am, weekends and bank holidays);
2) Confirm the immediate plan for the child (i.e. are they safe to be allowed home with their parent/carer?);
3) Agree what information can be shared with parents/carers and by whom; AND
4) Follow up with a written referral on the same working day

**Urgent referrals are required in any of the following circumstances:**

- **Children with life-threatening or significant injuries**
- **Bruises/marks/injuries in non-mobile children**
- **Bruises/marks/injuries suspected to be non-accidental or unexplained**
- **Disclosures of recent non-accidental injury and/or use of an implement**
- **Concerns for child's immediate safety**

## 4.4 What should parents/carers be told about referrals?

This flowchart is intended as a practical guide to support consistent practice but is not designed to cover all scenarios. Advice is aligned with:

- Draft statutory guidance for the information sharing duty (Jun 2026)
- Information sharing advice for safeguarding practitioners (May 2024)

Is this an urgent referral (see Section 4.3)? **Y →** Call Lambeth Children's Social Care to discuss and agree what can/should be said to parents/carers and agree who will be responsible for this:
- 0207 926 3100 (Mon-Fri 9am-5pm)
- 0207 926 5555 (Mon-Fri 5pm-9am, weekends and bank holidays).

**N ↓**

Do you believe that telling the parent/carer would jeopardise information gathering or pose a risk of harm to the child? E.g.
- Would it give a parent/carer an opportunity to coach a child?
- Would it give a parent/carer an opportunity to further harm a child?
- Would it give a parent/carer an opportunity to abscond with a child?

**Y →** Call Lambeth Children's Social Care to discuss and agree what can/should be said to parents/carers and agree who will be responsible for this:
- 0207 926 3100 (Mon-Fri 9am-5pm)
- 0207 926 5555 (Mon-Fri 5pm-9am, weekends and bank holidays).

**N ↓**

Parents/carers should be informed about:
- what information has been shared (e.g. a safeguarding concern has been raised),
- with whom it has been shared (e.g. and shared with children's social care), and
- why sharing was necessary to safeguard or promote the child's welfare (e.g. as required by our safeguarding policy).

If unsure about what to tell a parent/carer, please contact Lambeth Children's Social Care:

- 0207 926 3100 (Mon-Fri 9am-5pm)
- 0207 926 5555 (Mon-Fri 5pm-9am, weekends and bank holidays)

# 5. Multi-agency responses to referrals

## 5.1 Initial decision-making in Lambeth Children's Social Care & the role of the Integrated Referral Hub

When referrals are made into Lambeth Children's Social Care, it is the responsibility of the Integrated Referral Hub (IRH) to apply a RAG rating which sets out the expected timescales within which a final decision regarding threshold should be reached by IRH:

- Red – a threshold decision must be made within 4 hours.
- Amber – a threshold decision must be made within 48 hours.
- Green – a threshold decision must be made within 72 hours.

All cases meeting urgent referral criteria (see Section 4.3) will clearly meet the criteria for a Red RAG rating and, in these cases, a final threshold decision should normally be made immediately, without the need to utilise the full four-hour timeframe. The final threshold decision which should be applied should normally be that for S47 Enquiries (i.e. there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm), with clear evidence and rationale to support any decision-making where this threshold is not deemed met on urgent referrals.

As soon as IRH has determined a referral meets the threshold for S47 enquiries, IRH must refer to statutory social work teams as a matter of **immediate priority and urgency** without delay.

In all cases of bruising in children who are not independently mobile, the significant harm threshold is presumed met and must be progressed to statutory social work teams to convene a strategy discussion.

The remainder of this Protocol examines the multi-agency procedures for responding to children who are deemed to have met the threshold for S47 Enquiries where physical abuse is suspected.[2]

## 5.2 Strategy discussions and multiagency threshold decision-making

Where IRH has passed the referral on to a Lambeth statutory social work team, a strategy discussion must be convened (unless the social work team manager, upon review, determines that there is not a reasonable cause to suspect that a child is suffering or is likely to suffer significant harm).

It is the responsibility of Lambeth Children's Social Care to convene the strategy discussion. Specifically, statutory social work teams are responsible for convening the strategy discussion upon receipt of IRH referral.

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[2] Where the initial decision-making by IRH determines that the significant harm threshold is not met, the standard local procedures within Lambeth Children's Services Practice Standards for responding to Child in Need and Early Help cases applies.

Statutory social work teams must complete a Referral to Police Form 87A to notify the police that a strategy discussion is required.

Statutory social work teams and police should then liaise in the first instance to identify the urgency of the strategy discussion.

We use the terms '*standard strategy discussions*' and '*urgent strategy discussions*' to differentiate between the necessary action:

1) **Standard strategy discussions (within a maximum of 3 working days)** –
   - Must involve a social worker, health representative and police representative.
   - Best practice is to also include other bodies such as the referring agency, education, early help or other practitioners involved in supporting the child.
   - Consideration of the type and timing of any medical assessment must form part of this discussion. If there is likely to be a delay to the holding of this discussion, then more urgent advice should be sought from on call health professionals.
   - Lambeth Children's Social Care should inform the referring agency and health representative of the outcome and immediate protective actions agreed.
   - **Must be completed for all cases where significant harm is suspected**.

2) **Urgent strategy discussions (same day) – should be used to inform planned emergency action where there is a risk to the life of the child, a likelihood of serious immediate harm or for children in hospital -**
   - Must involve a social worker and police representative.
   - A health representative should be included if urgent health input is being considered, for example, consideration as to the appropriateness of a same day child protection medical or discussion as to how urgently any injuries may need to be assessed and treated.
   - The referring agency and/or school should be involved wherever possible.
   - If Police have already exercised Powers of Police Protection, the urgent strategy discussion should take place as soon as possible after action has been taken.
   - Lambeth Children's Social Care should inform the referring agency and health representative of the outcome and immediate protective actions agreed.
   - **Must be followed-up with a standard strategy discussion within 3 working days.**

For more information about strategy discussions in general, please refer to London Safeguarding Children Procedures, CP3.

## 5.3 Conduct of S47 enquiries by social workers

Please refer to London Safeguarding Children Procedures, CP3 and Lambeth's Practice Standards for general guidance regarding conduct of S47 enquiries by social workers.

Additional requirements specific to concerns around physical abuse include:

- Social workers will need to ensure that someone with parental responsibility has consented to any medical examinations (in all but the most life threatening cases).

- In situations where the usual caregiver is unable to accompany the child to the medical examination, the social worker should identify the most appropriate adult to:
  - Accompany and support the child with the medical examination, and
  - Provide background medical history (including contact information for the adult to enable these enquiries).
- Social workers will need to facilitate the child being able to be seen for the medical examination in a timely manner as agreed at the strategy discussion (e.g. support for transport).
- Social workers will need to update the medical professional with any key progress updates or changes since strategy discussion.
- If the child needs further investigations following medical examination (e.g. photography or blood tests), the social worker will need to accompany the child and family potentially to the hospital to enable and ensure completion.
- Social workers need to take account of medical findings, and seek clarity from a medical professional if they are unsure about the implications or significance of the findings.
- Any new allegations made during the medical examination, or findings that raise additional concerns, should prompt consideration by the social work team of a review strategy meeting. See Section 5.6 for further information on review strategy meetings.

## 5.4 Conduct of joint S47 enquiries by Police

It is important to recognise the distinct but complementary roles of agencies. Social work enquiries are primarily concerned with assessing need, risk and protective action for the child. In contrast, police investigations are required to determine whether a criminal offence has taken place and to secure admissible evidence.

This difference means that police activity operates to different evidential standards and legal thresholds. Unlike safeguarding enquiries, police investigations are not driven by prescribed timescales, as lines of enquiry must be pursued proportionately and in line with evidential requirements.

In addition, the use of policing powers (such as bail conditions), which may contribute to safeguarding, is dependent upon sufficient evidence being available to meet the relevant legal threshold. This means that whilst imposing bail conditions on a suspect may be desirable for safeguarding purposes, this option may not be available if evidential thresholds have not been established.

## 5.5 Child Protection medicals

### a) Purpose of a Child Protection Medical

The purpose of a Child Protection Medical is to:

- Provide documentation of any injuries (including a detailed body map and potentially clinical photographs)
- Hear the voice of the child
- Provide an opinion as to whether the injuries seen fit with the explanations provided
- Offer an opinion about potential mechanism of injury for some unexplained injuries (where appropriate)
- Arrange further investigations as necessary to further understand the degree of the injury and/or rule out alternative medical explanations for the marks seen
- Identify the child's health needs, initiate treatment and arrange any necessary follow up as required
- To advise social care about how broader health, wellbeing and developmental needs should be supported
- Provide a report (to social care, police, GP, other relevant health professionals and - where appropriate - police) to summarise the findings and implications (within 10 working days), a summary report may also be issued on the day **and, wherever possible, brief updates to police and social care should be provided.**
- To contribute to the multiagency assessment through sharing of information.

### b) How to decide when a Child Protection Medical is necessary

The decision about whether to offer a Child Protection (CP) Medical will normally be taken in the strategy discussion. In considering whether it is necessary to offer a CP Medical, the following factors should be considered:

- Whether there are known to be visible injuries (if so, a CP Medical should be offered within 24 hours of the concerns coming to light)
- The age and mobility of the child, particular attention is needed for non-mobile children because certain injuries do not usually occur as a result of an accident in non-mobile children. **In all cases of bruising in children who are not independently mobile, a CP Medical should be deemed necessary**.
- The time period in which the injury has suspected to have occurred and the associated likelihood of detecting medical evidence.
- The potential for cumulative physical and psychological impacts for the child which would necessitate a holistic health assessment
- Whether other children in the household should be offered a CP Medical

It is important to note that in situations where a child protection medical is not deemed necessary, this does not preclude the need to consider other safeguarding action or exclude wider potential abuse.

### c) Conduct & timing of a Child Protection Medical

Where possible, Child Protection Medicals will be undertaken during working hours by the Community Paediatric Team within 24 hours of referral for suspected physical injury. During non-working hours and in situations where urgent medical examination is required during working hours, medical examinations for physical abuse would be undertaken by the paediatric emergency department.

Only Paediatricians with appropriate paediatric and child protection training should physically examine the whole child for the purposes of a Child Protection medical assessment. It is not appropriate to send a child to their GP for a safeguarding medical.

### d) Consent to Child Protection Medicals

Consent is needed to undertake a Child Protection Medical. Consent can be provided by:

1) A child of 16 and over (with capacity)
2) A child of under 16 where a doctor considers he or she is of sufficient age and understanding to give informed consent, is “Gillick Competent”
3) Any person with Parental Responsibility (PR)
4) The local authority when the child is the subject of a Care Order (although the parent/carer should be informed)
5) The local authority when the child is accommodated (Looked After) and the parent/carers have abandoned the child or are physically or mentally unable to give such authority
6) The High Court when the child is a Ward of Court
7) A Court as part of a direction attached to an Emergency Protection Order, an Interim Care Order or a Child Assessment Order.

In the absence of a Court Order or circumstance above, consent to the medical must usually be obtained from the person/s holding parental responsibility (this is usually the parent/s or carer with PR) prior to the medical being arranged. The parents should be told why a medical is required and the potential options available if they do not co-operate and where necessary they must be supported to obtain free legal advice.

If the child is over 16 and/or under 16 and Gillick competent then they can also consent (in whole or part) to the medical even if the parents refuse (or in very rare circumstances it is not appropriate to contact a parent). A view about the appropriateness of this will need to be taken by the social worker and professional group based on their knowledge/understanding of the child.

If the medical is urgent (usually severe physical injury) and no parent or carer with PR can be contacted then an assessment can go ahead if deemed to be in the child’s best interests. Permission should be given by Lambeth Children’s Social Care/Police, albeit where there are pressing time constraints medical professionals may override this to provide timely medical care. Legal advice should be normally be sought in these circumstances.

If cases where a child who is Gillick Competent does not consent to a medical their wishes should be respected and the examination cannot proceed if the young person fully understands this decision. If necessary legal advice should be sought.

For the rare cases where a parent/carer withholds consent. All efforts should be made to discuss examination with the parent/carer and gain consent before legal advice is sought. If there is no indication of injury/ life threatening illness the following should be considered:-

- Further strategy discussion with police, social care and paediatrician as to the importance and value of the medical assessment.
- Dispute Resolution.
- Parents being supported to access independent legal advice.

If a medical assessment is still required, the local authority (via children's social care) should consider and obtain legal advice about an application to the court.

The decision as to the order sought is a matter for the local authority and is made having considered all the relevant information.

## 5.6 Function of review strategy discussions

Review strategy discussions can be convened once a S47 enquiry has begun *if* there is a clear rationale to do so. These reviews should not be a routine process. For physical abuse concerns, a review strategy meeting may be appropriate where:

- New information has come to light during the course of the enquiry, including during Child Protection Medical, that indicates that further enquiries may be needed and/or key decisions may need to be revisited.
- The agreed approach to progressing the S47 enquiry could not proceed as planned (e.g. where a Child Protection Medical could not take place due to consent not being obtained), requiring a multi-agency review of risk, protective factors, and the next steps, including whether the enquiry should continue, change direction, or conclude.

When more than 1 strategy discussion is necessary, the reconvened discussion should take place in a timely manner. Attendance requirements are the same as for the first strategy discussion.

### 5.7 Substantiation of significant harm & threshold for ICPC

At the completion of a S47 enquiry, it is for social work teams to determine whether or not the threshold for Initial Child Protection Conference (ICPC) is reached. To meet threshold:

- The harm must be substantiated, and
- The child must be judged to be suffering, or likely to suffer, significant harm.

**Substantiation of harm does *not* depend on medical evidence or an admission by parents or carers**. All sources of information – including the voice of the child – must be carefully weighed to inform a professional judgement as to whether harm has occurred.

If harm is substantiated, professional judgement is used to inform whether harm is likely to occur in future and what level of response is required to reduce future risk (with reference to the Pan-London threshold document).

## 6. Dispute resolution and escalations

Where there is disagreement amongst involved practitioners, or a concern regarding failure to follow expectations and standards within this protocol, Lambeth Safeguarding Children Partnership's Escalation Policy must be followed to achieve resolution.

## 7. Protocol sign-off and reviews

This Protocol has been developed by a multiagency working group across Lambeth Children's Social Care, Guys' & St Thomas's NHS Trust and Central South BCU Child Abuse Investigation Teams.

Version 1 of this Protocol was ratified by the LSCP Executive Board in August 2026.

This Protocol will be reviewed every three years, unless changes in legislation, statutory guidance, or local practice require an earlier review.

# Appendix A – reference documents

The Protocol is informed by and aligns with:

- Children Act 1989
- London Safeguarding Children Procedures
- Working Together to Safeguard Children (March 2026)
- Lambeth Children's Services Procedures Manual
- Lambeth Children's Services Practice Standards 2025
- Royal College of Paediatrics and Child Health Child Protection Companion
- NICE Clinical Guidance: Child maltreatment: when to suspect maltreatment in under 18s (reviewed Dec 2025)
- College of Policing APP (Authorised Professional Practice)
- Police and Criminal Evidence Act 1984 (PACE) codes of practice
- The management of bruising in non-mobile infants paper from the National Child Safeguarding Review Panel (Sep 2022)
- Draft statutory guidance for the information sharing duty (Jun 2026)
- Information sharing advice for safeguarding practitioners (May 2024)