



## THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

### PROCEDURES FOR THE OPHTHALMOLOGIST WHO SUSPECTS CHILD ABUSE

All NHS Trust hospitals that deal with children should have a **Named Doctor (ND) and Named Nurse (NN)** with particular expertise in child protection. They have responsibility for providing appropriate training and dissemination of local child protection guidelines. The ND is usually a consultant paediatrician, but in an Eye Hospital the ND may be an Ophthalmologist who will need to have links with the Named Doctor (Paediatrician) in a neighbouring trust.

In addition, every Health Authority or Board appoints a **Designated Doctor and Designated Nurse** in child protection, who are available for advice.

Local guidelines should be readily available to all staff working with children: they identify key personnel together with relevant telephone numbers including those of the local Social Services and the Police Child Protection offices.

#### SUSPECTING ABUSE OR NEGLECT

Many forms of child abuse may involve the eye and they may coexist. The Ophthalmologist mainly encounters physical abuse (indirect trauma, shaking, smothering and direct eye trauma), and occasionally induced illness (Munchausen Syndrome by proxy), sexual abuse, neglect, and emotional abuse.

#### WHAT TO DO IF YOU SUSPECT CHILD ABUSE OR NEGLECT

Professionals should not intervene on their own and all suspicions should be discussed with the hospital social worker and ND. When child abuse is felt to be occurring there is a responsibility to inform the social services office

1. If a trainee **suspects** abuse or neglect, there should be immediate **consultation** with a senior colleague, the senior nurse of the ward or department, and the consultant Ophthalmologist in charge of the case to confirm suspicions of abuse.

2. There should be early **consultation** with the Named Doctor and Nurse, who will frequently be responsible for the further investigation and general medical management. In Trusts where there is no Named Doctor, the consultant Ophthalmologist or the Paediatrician in charge of the case should decide the lines of responsibility and discuss the case with the Designated Doctor.

3. **Admission** may be necessary if the named doctor is not readily able to see the child or if there are grave injuries or serious suspicions about the immediate risks to the child. A full history must be taken and an examination of the patient made, including non-ocular areas of the body if the Paediatrician has not yet become involved. There must be full **documentation** of the history, including what is said by all parties, and the physical findings must be noted, with annotated drawings and photography where possible. Early involvement of a paediatrician is advisable.

4. If, after consultation, abuse or neglect is still considered a possibility, a **referral** will be made by the Named Doctor to the Social Service Department, via the hospital's social worker, if there is one, or directly if there isn't. The responsibility for investigating suspected child abuse lies with the Local Authority Social Services department and the Police Child Protection team

#### LOCAL TELEPHONE CONTACTS

Named Doctor: \_\_\_\_\_

Named Nurse: \_\_\_\_\_

Paediatrician: \_\_\_\_\_

Designated Doctor: \_\_\_\_\_

Local Social Service Office: \_\_\_\_\_

Police Child Protection Team: \_\_\_\_\_

Enter the telephone numbers of the above in the spaces provided

#### PRESENTATIONS, INJURIES OR BEHAVIOURAL STATES WHICH SHOULD ALERT THE CLINICIAN

##### Children at risk

- Premature, handicapped, and crying babies,
- Siblings of abused children,
- Children of previously abused parents.

##### Worrying factors in the presentation

- The account of how the injuries occurred is inconsistent with their appearance.
- The apparent age of injuries is inconsistent with the account given, or a delay in presentation.
- Unexplained injuries.
- Injuries blamed on siblings
- Multiple attendances at A&E departments.
- An unusual lack of parental concern at the severity or extent of the injuries.

##### Eye signs suggestive of abuse

- Retinal haemorrhages
- Periocular bruising, lid lacerations

- Unexplained lens dislocation or cataract
- Unexplained conjunctival or corneal injuries, especially in the lower half of the eye

##### Other signs of abuse

- Head or face injuries in infants or non-mobile children
- Subdural or subarachnoid haemorrhages.
- Bite marks, scalds or fingertip bruising.
- Cigarette burns, especially if multiple.
- Unusual injuries in inaccessible sites, e.g. neck, armpit, groin etc.

##### Neglect

When a child presents dirty and unkempt or where there is worrying, e.g. aggressive, hyperactive behaviour, this should be discussed with the hospital social worker and consideration given to discussing this further with the GP or Health Visitor. Similar procedures should be observed when parents behave aggressively towards their children, or show unusual behaviour towards hospital staff. This particularly applies if drug or alcohol abuse is suspected.

#### PRINCIPLES

##### Informed Consent

to medical examination should be obtained from an adult with parental responsibility for the child, and from the child, in a manner appropriate for age and level of understanding. Medical examination can be carried out with only the child's consent when, in the opinion of the doctor, the child has sufficient understanding

##### Refusal to give consent

If the carer or the child refuse to give consent or to cooperate with admission or treatment, the doctor should inform the Consultant in charge or the Named Doctor immediately: it may be necessary to consider emergency legal action, initiated by the Social Services Department or the Police.

##### Children's Rights

Children have a right to know what is going on. They should not be made promises that cannot be kept, and their views and wishes should be taken into

consideration. They should be given the opportunity to explain what has happened to them, but probing and confrontational 'disclosure' interviews should not be carried out. Physical examinations should be few, and carried out in a suitable environment by appropriately trained staff and in the presence of a trusted adult.

##### Parents' or Carers' Rights

Carers are entitled to know what is going on and to be helped to understand the steps being taken, but the child's welfare is paramount. If the child is under a Child Protection Order or accommodated by the Local Authority, arrangements for contact with the family should be clarified with Social Services.

##### Evidence

Therapeutic needs take precedence over evidential requirements. Accurate and unbiased records are essential for case conferences, and legal proceedings which may be the ophthalmologists duty to take part in.

#### References

- 1). Working together to safeguard children, 1999 (Child Protection: Medical Responsibilities, Child Protection: Arrangements between the NHS and other agencies, are addenda to the above)
- 2). Child abuse and the eye. report of the British Ophthalmology child abuse working party. Eye 1999; 13: 3-10
- 3). Duhaime A-C et. al. Non-Accidental Injury in Infants, N E J Med 1998;338 1822-1829
- 4). "Handle with Care" NSPCC document for parents, National Centre, Curtain Road London EC23NH

This document was prepared by the Ophthalmology Child Abuse Working Party (ref.2), 4.3.1999 in discussion with The Royal College of Paediatrics and Child Health Standing Committee on Child Protection.



The Royal College of Ophthalmologists  
17 Cornwall Terrace, Regent's Park, London NW1 4QW