



Manchester Royal
Eye Hospital

Re- audit: Quality of documentation of ophthalmic findings in infants and young children with suspected non- accidental injury (NAI): A Medicolegal prospective



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INTRODUCTION : Clear and comprehensive documentation of ophthalmic findings is essential in the preparation of medicolegal reports that support the Family Court in making complex safeguarding decisions. Increasingly, courts are requesting clarification regarding the reliability of ophthalmic findings and whether documentation complies with recommendations issued by the Royal College of Ophthalmologists. Incomplete or inconsistent documentation may reduce the evidential weight of ophthalmic assessments and contribute to delays in judicial proceedings. The Royal College of Ophthalmologists guideline, *Abusive Head Trauma and the Eye: 2024 Guidelines*, was developed to support ophthalmologists in recording ocular findings in a standardised, reproducible, and clinically robust manner. The guidance clearly states the standards of the ophthalmology assessment and that ‘a standardised clinical proforma designed for documentation should be used’.

Abusive Head Trauma remains the leading cause of severe neurological morbidity and mortality in infancy. The annual incidence of inflicted head injury is estimated at 24.6 per 100,000 children under one year of age, with a median age at presentation of just over 8 weeks. Ophthalmologists are frequently asked to assess these infants for evidence of ocular injury, most commonly retinal haemorrhages and subconjunctival haemorrhages.

In 2009, WN, one of the authors and an Expert Witness in both criminal and family proceedings involving suspected child maltreatment, identified thirteen key elements of information that should reasonably be documented within the ophthalmic clinical record. An audit was subsequently undertaken to assess compliance with these standards, leading to recommendations including the introduction of a structured proforma. These findings were presented as a poster at the 2009 Annual Congress, followed by a re-audit in 2021.

PURPOSE: The audit was designed to evaluate the quality and completeness of documentation of ocular findings in cases of suspected non-accidental injury examined by ophthalmologists. Compliance with the 2024 Royal College of Ophthalmologists guidelines was assessed.

METHOD: Ophthalmology records from 20 consecutive cases reviewed between August 2024 and July 2025 were analysed. The co-author (WN) acted as a court-appointed Single Joint Expert Witness in Family Court proceedings and provided independent reports and interpretation of the ophthalmic findings. Documentation of 13 predefined clinical parameters was assessed against the 2024 Royal College of Ophthalmologists guidelines. The quality and completeness of documentation were also compared with findings from previous audits conducted in 2009 and 2021.



	ITEMS OF INFORMATION	2024 AUDIT RESULTS	2019 AUDIT RESULTS	2009 AUDIT RESULTS
		AFTER 2024 Guideline	AFTER 2013 Guidelines	No Guidelines
1 a	Was the RCOphth proforma used?	50% (10/20)	55% (11/20)	NA
1b	Was there a patient identifier present on each page written upon by ophthalmologist	100% (20/20)	40% (8/20)	70%
2	Was the name of ophthalmologist written and eligible	85% (17/20)	85% (17/20)	61.50%
3	Was grade of ophthalmologist indicated	70% (14/20)	50% (10/20)	54%
4	Date of examination	95% (19/20)	100%	100%
5	Time of examination	70% (14/20)	70% (14/20)	54%
6	Anterior segment examination	100% (20/20)	85% (17/20)	46%
7a	Was it indicated that pupil were dilated	90% (18/20)	100%	54%
7b	Was the drops used indicated	85% (17/20)	90% (18/20)	54%
7c	Was time of application indicated	25% (5/20)	30% (6/20)	54%
8	Was it indicated that infant was awake/ asleep/wrapped/unconscious	15% (3/20)	45% (9/20)	23%
9	Speculum used or not	15% (3/20)	20% (4/20)	15%
10	Indicated if rotation/indentation used	0% (0/20)	10% (2/20)	7%
11	Instruments used for fundal examination	65% (13/20)	85% (17/20)	7%
12a	Were retinal photographs taken	55% (11/20)	65% (13/20)	30%
12b	If photograph taken , was this indicated in clinical records	90% (10/11)	100% (13/13)	50%
13	Was there detailed description of findings with or without illustration	50% (10/20)	80% (16/20)	61%

OPHTHALMOLOGY PATIENT RECORD
FOR SUSPECTED PAEDIATRIC HEAD TRAUMA

For use by a doctor

HISTORY

PATIENTS DETAILS

Visual Acuity Right eye Left eye

OCULAR MOTILITY Right eye Left eye

SUBCONJUNCTIVAL HAEMORRHAGES Right eye Left eye

PERIODIC BRUISING (check areas of bruising)

FUNDUS Circle if present

Retinal Haemorrhages YES NO YES NO

NUMBER of Retinal haemorrhages Few (1-10) Many (11-20) Too numerous to count Few (1-10) Many (11-20) Too numerous to count

LOCATION of retinal haemorrhages Pre retinal Intraretinal Subretinal Multilayered Pre retinal Intraretinal Subretinal Multilayered

DISTRIBUTION of retinal haemorrhages Posterior Pole Few/many/ too numerous to count (Zone 1 - ROP classification) Periphery Few/many/ too numerous to count (outside Zone 1) Posterior Pole Few/many/ too numerous to count (Zone 1 - ROP classification) Periphery Few/many/ too numerous to count (outside Zone 1)

SIZE of retinal haemorrhages Small (< 1dd) Medium 1-2dd Large >2dd Small (< 1dd) Medium 1-2dd Large >2dd

MORPHOLOGY of haemorrhages Macula Retinopathy Perimacular folds Optic disc (findings) oedema

Summary

Management plan

Name and signature

Pupils dilated with Phenylephrine 2.5% Tropicamide 1% 0.5%

Fundus examined with Indirect ophthalmoscope (and 2dd / 2dd / 2dd / 2.2dd) Photography White angles Contour Other GOT

Date and time of examination

Recording sheet as recommended within the RCOphth 'Abusive Head Trauma and the Eye', January 2024

<https://www.rcophth.ac.uk/resources-listing/abusive-head-trauma-and-the-eye-in-infancy/>

CONCLUSION

Appropriate local education, training, and regular audit processes should be implemented to improve compliance with national documentation standards and enhance the quality and consistency of ophthalmic medicolegal reporting in this important area of safeguarding.

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Discussion: Clear and comprehensive documentation of ophthalmic findings is essential in the preparation of medicolegal reports that assist the Family Court in making highly complex safeguarding decisions, including cases where an infant may ultimately be removed from parental care.

This repeat audit demonstrates that, despite the availability of national guidance since 2013, uptake and consistent use of the recommended recording proforma remain suboptimal.

Treating ophthalmologists are infrequently required to provide oral evidence in court; consequently, documentation that may appear clinically adequate at the time of examination may subsequently prove insufficient within a medicolegal context many months later.

Incomplete or non-standardised records may limit the ability of ophthalmic experts to provide robust opinions, particularly where detailed clinical descriptions and supporting information are lacking.

RESULTS: In only 50% of cases (10/20) were the ophthalmic findings documented using the recommended Royal College of Ophthalmologists Abusive Head Trauma proforma submitted to the Court. In the remaining 10 cases, it was confirmed that no proforma had been completed. The table below summarises the detailed audit findings.