

Assessment of Neonatal Subconjunctival Haemorrhage (SCH) Policy

V1.0

June 2026

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Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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1. Introduction

This policy supports proportionate clinical and safeguarding decision-making, reduces unnecessary escalation, and ensures that potential medical or safeguarding risks are appropriately identified and managed.

2. Purpose of this Policy/Procedure

To provide a clear, pragmatic, and defensible framework for the assessment of subconjunctival haemorrhage (SCH) in neonates in Cornwall that were not identified/documentated at their initial newborn examination, balancing safeguarding vigilance with recognition of the predominantly benign nature of birth-related SCH.

3. Scope

This guideline applies to neonates (birth to 28 days of age) and is relevant to all healthcare professionals involved in their care, including midwives, maternity support workers, health visitors, general practitioners, paediatricians, and other professionally registered clinicians working across maternity, community, primary care, and hospital settings.

4. Definitions/Glossary

Subconjunctival haemorrhage (SCH) refers to bleeding beneath the conjunctiva, presenting as a sharply demarcated red area on the sclera (white of the eye).

Most neonatal SCH occurs during or shortly after birth, particularly following vaginal delivery, due to increased thoracic and venous pressure leading to rupture of fragile conjunctival vessels. Reported prevalence ranges from approximately 1 to 31% of neonates.

Instrumental delivery is associated with an increased risk of retinal haemorrhage but is not strongly associated with subconjunctival haemorrhage.

Birth-related SCH is usually benign, self-limiting, and resolves spontaneously within 1 to 2 weeks.

Traumatic inflicted subconjunctival haemorrhage is rare, and subconjunctival haemorrhage in isolation- that is, in the absence of other concerning clinical findings, injuries, or safeguarding indicators- is seldom a sentinel sign of abuse; however, context, timing, and associated findings remain critical to assessment.

Subconjunctival haemorrhage newly detected after 14 days of age is uncommon. Although delayed detection can occur, true late-onset SCH is not characteristic of birth-related injury and should prompt increased professional curiosity and paediatric clinical review to assess for medical causes and potential traumatic mechanisms.

5. Ownership and Responsibilities

This section outlines the strategic and operational responsibilities for the development, dissemination, implementation, and governance of this policy. It provides clarity for staff regarding their individual and collective roles in supporting safe, consistent, and proportionate practice.

5.1. Lead Executive

Chief Medical Officer, Royal Cornwall Hospitals NHS Trust.

5.2. Responsible Reporting Group

Child Health Audit and Guidelines Group, reporting through Trust clinical governance and safeguarding structures.

5.3. Lead Professional

- Named Doctor for Safeguarding Children, Royal Cornwall Hospitals NHS Trust.
- Author/Clinical Lead: Consultant Paediatrician with responsibility for child protection and safeguarding guidance within Child Health.

5.4. Sub-Groups

- Safeguarding Operational Group (SOG).
- Child Health Directorate Governance and Audit Meetings.
- Relevant maternity and neonatal governance forums as required.

5.5. Divisional Management Team

The Child Health Directorate Management Team is responsible for ensuring that this policy is supported within directorate governance arrangements and that systems are in place to enable its effective implementation.

5.6. Role of the Managers

Line managers are responsible for:

- Ensuring staff are aware of this policy and understand their responsibilities within it.
- Supporting staff to follow the guideline in clinical practice.
- Facilitating access to safeguarding advice, paediatric review, and escalation pathways as required.
- Supporting reflective practice and learning where cases raise concern or uncertainty.

5.7. Specialist Staff

Specialist staff, including paediatricians, safeguarding professionals, and senior midwives, are responsible for:

- Providing expert clinical advice and review when escalation is required.
- Supporting proportionate safeguarding decision-making.
- Contributing to audit, learning, and guideline refinement through governance processes.

5.8. Role of Individual Staff

All clinical staff involved in the care of neonates are responsible for:

- Adhering to this guideline and applying it using professional judgement.
- Undertaking and documenting a full head-to-toe examination where SCH is identified.
- Escalating concerns appropriately in line with this policy.
- Clearly documenting clinical findings, decision-making, and rationale.
- Communicating openly and sensitively with families, unless doing so would increase risk to the child.

6. Standards and Practice

6.1. Key Principles:

- Birth-related SCH is common and usually benign.
- Traumatically inflicted SCH in isolation are not common and in the absence of other concerning features are not typically identified as a sentinel injury.
- Context, timing, mode of delivery, and associated findings are critical.
- Medical illness always takes priority.
- Clear documentation and communication with families underpin safe, defensible and pragmatic practice.

6.2. Initial Assessment (all cases).

- Full head-to-toe examination with infant fully undressed.
- Assess clinical wellbeing (feeding, tone, alertness, fontanelle).
- Examine the SCH itself (size, laterality, progression, recurrence, associated ocular injury).

- Consider mode of delivery, timing, and social context.
- Document positive and negative findings.
- Are there any family pictures immediately after delivery or in the first few days that the SCH can be seen in?
- If SCH is first identified by a Maternity Support Worker (MSW), the infant must be examined by the lead or supervising midwife initially.

6.2.1. Timing Matters.

SCH first detected:

- ≤14 days of life: birth-related SCH more likely.
- >14 days of life, or timing unclear:
 - Uncommon.
 - Paediatric clinical review required to assess medical and potential traumatic causes.
 - Increased professional curiosity warranted.

6.2.2. Mode of Delivery.

- Vaginal delivery or caesarean following labour (including difficult/prolonged labour). Birth-related SCH more likely.
- Elective caesarean section with no labour.
 - Birth-related SCH less likely.
 - Lower threshold for review and caution.

6.3. When SCH Can Reasonably Be Considered Birth-Related?

A registered health professional (Midwife, HV (Health Visitor), GP (General Practitioner), Paediatrician) may reasonably conclude SCH is birth-related if all apply:

- SCH detected ≤14 days of life.
- Vaginal or labour-associated caesarean delivery.
- Infant clinically well.
- Complete head-to-toe examination with no concerning findings.
- No concerning SCH features (small, non-progressive, not recurrent, no peri-orbital injury).
- No social or safeguarding concerns (background considered; Social Care

check if needed).

- **This decision and rationale must be clearly documented.**

6.4. When to Escalate:

- Any clinical illness.
 - Urgent medical referral (medical priority).
- SCH first detected >14 days, atypical SCH features, elective CS (Caesarean Section) with no labour.
 - Discuss with paediatric team.
 - Likely paediatric clinical review.
- Additional injuries, concerning history, or safeguarding concerns.
 - Seek safeguarding advice.
 - Consider MARU referral.

If you are uncomfortable with any aspect of the case call the paediatric team

6.5. Bottom Line.

- Most neonatal SCH is benign and birth-related.
- >14 days, elective CS without labour, atypical features, or unease → pause and review.
- Document clearly, escalate proportionately, prioritise medical illness.
- Professional judgement is supported when applied systematically.

6.6. Key Clinical and Social Features Influencing Risk:

Feature	Lower-risk characteristics	Features increasing concern
Timing of detection.	Present at birth or within first 14 days; documented in birth or NIPE (Newborn Infant Physical Examination) records.	Newly detected after 14 days, or unclear timing.
Mode of delivery.	Vaginal delivery or caesarean section following labour.	Elective caesarean section with no labour or documented trauma.
Size and laterality.	Small, unilateral; bilateral possible.	Large, bilateral, recurrent, or increasing.

Feature	Lower-risk characteristics	Features increasing concern
Associated injuries.	Isolated SCH.	Retinal haemorrhages, bruising, fractures, inconsistent history.
Neonatal wellbeing.	Clinically well.	Poor feeding, lethargy, hypotonia, bulging fontanelle, fever.
Social context.	No safeguarding concerns.	Domestic abuse, substance misuse, prior child protection involvement, delay in presentation.

6.7. Initial Clinical Examination.

The health professional identifying the SCH must undertake a **complete head-to-toe examination with the infant fully undressed**.

This should include:

- Inspection for bruising, petechiae, marks, or other injuries.
- Assessment of general wellbeing including feeding, alertness, tone, and fontanelle.
- Documentation of findings using a body map where appropriate.
- Recording of significant negative findings as well as positive findings.

Where SCH is first identified by a Maternity Support Worker (MSW), the infant should be assessed and examined by the supervising or lead midwife in the first instance, in line with local maternity governance arrangements. Further escalation should then follow this guideline based on clinical findings and risk assessment.

6.8. Other Medical Conditions Associated with SCH.

- Potential non-traumatic causes that should be considered include:
- Coagulation disorders (e.g. thrombocytopenia, haemophilia, von Willebrand disease).
- Infection, including ophthalmia neonatorum or severe systemic infection.
- Raised venous pressure (e.g. severe coughing or vomiting).
- Birth-related complications including traumatic delivery or hypoxic events.
- Rare systemic or iatrogenic causes.

6.9. Assessment and Documentation.

6.9.1. History.

- Establish when SCH was first noticed and how this is corroborated (records and/or photographs).
- Review mode of delivery, including whether labour occurred.
- Review gestation, birth weight, and perinatal history.
- Explore any recent illness or events that could raise venous pressure.
- Consider safeguarding history and social context.

6.9.2. Physical Examination.

- Confirm whether SCH is isolated.
- Identify any additional injuries or signs of illness.
- Assess overall neonatal wellbeing.

6.9.3. Social Assessment.

Where uncertainty exists, clinicians should consider seeking relevant background information from Children's Social Care via MARU (Multi Agency Referral Unit).

6.9.4. Documentation.

- Clearly record timing of detection and examination findings.
- Describe SCH characteristics and absence or presence of concerning features.
- Document mode of delivery and relevance to risk assessment.
- Record social context and clinical reasoning.
- Update MARU if already involved.

6.10. Risk Stratification and Recommended Actions

Scenario	Risk level	Action
Isolated SCH ≤ 14 days, vaginal or labour-associated caesarean birth, well neonate, no social concerns.	Very low.	Reassure, document clearly, routine follow-up.
SCH newly detected >14 days, uncertain timing, atypical SCH features, or elective caesarean section with no labour.	Increased.	Paediatric clinical review required; discuss with safeguarding lead.
SCH with associated injuries or safeguarding concerns.	High.	Immediate safeguarding referral and multidisciplinary assessment.
SCH with signs of illness or neurological symptoms.	Potentially high.	Urgent paediatric review; medical priority.

6.11. Decision Tool for Neonatal SCH:

See flowchart on following page.

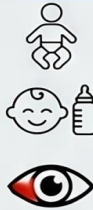
Neonatal Subconjunctival Haemorrhage (SCH) Clinical Decision Tool

Key Principles

- **Birth-related SCH is common and usually benign.** It is a frequent occurrence following vaginal or labour-associated deliveries and generally resolves spontaneously within 14 days.
- **SCH in isolation is rarely a sentinel sign of abuse.** In the absence of other injuries or concerning features, isolated SCH is seldom an indicator of non-accidental injury.

Context, timing, and delivery mode are critical. Clinical decision-making must be based on how, when, and in what social context the haemorrhage was identified.

Step 1: Initial Assessment



Conduct a full 'Head-to-Toe' examination. The infant must be fully undressed to check for bruising, petechiae, or other injuries.

Assess clinical wellbeing. Evaluate the infant's feeding patterns, muscle tone, alertness, and the state of the fontanelle.

Examine SCH characteristics. Note the size, laterality (one eye or both), and whether the SCH is progressive or recurrent.

Red Flags (Medical & Safeguarding Priority)



Identify urgent Red Flags. Signs include an unwell infant, neurological concerns (seizures, bulging fontanelle, lethargy), unexplained bruising, or other injuries (fractures, burns).

Immediate Action Required. If any Red Flag is present, treat as a medical priority and seek an urgent paediatric referral and/or safeguarding review immediately.

Step 2: Timing and Context



≤ 14 Days of Age

Detection within the first two weeks is typically consistent with birth-related SCH, especially following vaginal or labour-associated caesarean delivery.



> 14 Days or Uncertain Timing

SCH newly detected after 14 days is uncommon and not characteristic of birth-related injury; this requires a paediatric clinical review.

Step 3: Risk Stratification



Low Risk (Action: Reassure)

Isolated SCH detected ≤14 days after a vaginal/labour delivery in a well infant with no social concerns.



Increased Risk (Action: Pause and Review)

Cases involving elective caesarean section with no labour, atypical SCH features, or social concerns require discussion with the paediatric team or safeguarding lead.

Management & Documentation



Parental Reassurance for Low-Risk Cases. Advise parents that SCH is self-limiting, usually resolves in 1–2 weeks, and requires no specific treatment.



Essential Documentation Items. Record delivery history, SCH description (size/laterality), and exam findings in both medical notes and the baby's 'Red Book' (PCHR).



Advise on worsening symptoms. Instruct parents to seek medical advice if the infant develops swelling, poor feeding, or vomiting.



Clinical Contacts



RCHT Paediatric Registrar/Consultant. Contact via **01872 250000** (Available 24 hours).



Multi-Agency Referral Unit (MARU). Contact via **0300 123 1116** for safeguarding concerns.

6.12. Cornwall-Specific Safeguarding and Clinical Contacts.

- Paediatric registrar or consultant (RCHT).
Available 24 hours a day via the RCHT switchboard.
Tel: 01872 250000.
- Multi-Agency Referral Unit (MARU).
Tel: 0300 123 1116.
- Out of Hours Children's Social Care.
Tel: 01208 251300.

6.13. Summary.

SCH identified within the first 14 days of life following vaginal delivery or labour-associated caesarean section, in a clinically well neonate with no social risk factors, is usually benign.

Where SCH is noted for the first time within the first 14 days of life following vaginal delivery, and there are no indicators of clinical or safeguarding concern, a professionally registered health professional (midwife, health visitor, GP, paediatrician) may reasonably conclude that the SCH is birth-related if all of the following apply:

- A complete head-to-toe examination has been undertaken with the infant fully undressed.
- There are no additional findings of concern, including bruising, marks, signs of injury, neglect, or illness.
- The infant is clinically well.
- There are no identified social or safeguarding concerns, having considered available background information; where uncertainty exists, this may include seeking relevant background information from Children's Social Care.
- The SCH itself has no concerning features on examination (e.g. small, non-progressive, not recurrent, and without associated ocular or peri-orbital injury).

This decision-making process and the presence and characteristics of the SCH must be clearly documented.

If any elements of concern are present, or if the clinician is uncomfortable with any aspect of the history, examination, or context, advice and review should be sought from the paediatric team.

If the infant is clinically unwell, urgent medical referral must take priority. The receiving team should be informed of the SCH and any identified concerns.

SCH newly detected after 14 days of life, with no prior professional documentation or corroborative evidence of earlier presence, is uncommon and requires discussion with the paediatric team and will usually require paediatric clinical review.

Any presentation that moves away from low risk as defined in this guideline should prompt discussion with the paediatric team and consideration of referral to MARU. Where discussion with Social Care is indicated, this should normally be explained to the family unless doing so would increase risk to the child.

7. Dissemination and Implementation

This policy will be disseminated to all staff via email and publication on the Documents Library. Any new version of this policy will be recirculated and all relevant staff made aware of the updates.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with the policy.
Lead	Named Doctor for Safeguarding Children, Royal Cornwall Hospitals Trust.
Tool	Case note review and targeted audit.
Frequency	As required through safeguarding review processes, serious incident review, complaints, or learning events; and periodically if concerns are identified.
Reporting arrangements	Safeguarding Operational Group (SOG).
Acting on recommendations and Lead(s)	Child Health Directorate Audit and Guidelines Meeting, in conjunction with the Named Doctor for Safeguarding Children.
Change in practice and lessons to be shared	Any learning identified through audit, case review, or safeguarding processes will be reviewed by the Named Doctor for Safeguarding Children. Where changes to practice are required, these will be actioned within 3–6 months and disseminated through appropriate channels, including: • Safeguarding Operational Group (SOG). • Child Health Directorate governance meetings. • Relevant clinical teams across maternity, paediatrics, and community services. Learning points will be shared with relevant stakeholders to support safe, consistent, and proportionate practice.

9. Updating and Review

This document will be updated every 3 years, or earlier if indicated.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity and Inclusion Policy](#) or the [Equality and Diversity website](#).

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Assessment of Neonatal Subconjunctival Haemorrhage (SCH) Policy V1.0
This document replaces (exact title of previous version):	New document
Date Issued/Approved:	June 2026
Date Valid From:	June 2026
Date Valid To:	June 2029
Author/Owner:	Tom Fontaine; Paediatric Consultant
Contact details:	Telephone 01872252716
Brief summary of contents:	This guideline provides a structured, evidence-informed framework for the assessment of neonatal subconjunctival haemorrhage, balancing safeguarding vigilance with recognition of the predominantly benign nature of birth-related SCH. It supports proportionate escalation, clear documentation, and appropriate communication with families.
Suggested Keywords:	Neonatal, Subconjunctival Haemorrhage, Safeguarding, Child Protection, Non-Accidental Injury.
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Child Health Audit and Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	Working Together to Safeguard Children (2018, updated 2023); RCPCH Child Protection Companion; NICE CG89.

Information Category	Detailed Information
Related Documents:	Safeguarding Children Policy; Injuries in Non-Mobile Infants (INMI) Pathway; Child Protection and Information Sharing Policy; Maternity Governance Framework.
Training Need Identified:	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Paediatrics / Procedures

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
April 2026	V1.0	Initial issue	Tom Fontaine; Paediatric Consultant.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#).

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net.