



Concealed and or Un-Declared Pregnancy & Birth Guidance for Professionals.

Acknowledgements:

West Sussex

Relevant Agencies

To be used in co- junction with the All London Child Protection Procedures

A multi-agency Working Group of the West Sussex Local Safeguarding Children Board (LSCB) produced this guidance.

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In developing this guidance for West Sussex, acknowledgment is made to Staffordshire LSCB and to the work of Gill Earl

- The Children Acts 1989 and 2004.
- Framework for the Assessment of Children in Need and their Families (DoH 2000).
- Working Together to Safeguard Children (2013).

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1. Purpose of the guidance

- 1.1 This guidance is intended for professionals who may encounter women who conceal the fact that they are pregnant or where there is a known previous concealed pregnancy.
- 1.2 This guidance should be applied in conjunction with any internal agency procedures and with the All London Child Protection Procedures (2010), with particular reference to sharing information (Section 3) and Pre-birth Child Protection Procedures (Section 8.14).
- 1.3 While concealment by its nature limits the scope of professional help, experience shows that better outcomes can be achieved by co-ordinating an effective inter-agency approach once the fact of the pregnancy is established. This will also apply to future pregnancies where there has been a previous concealed pregnancy.
- 1.4 All professionals from statutory and voluntary agencies who provide services to young people and women of childbearing age should be aware of the risk indicators of concealed pregnancy and how to act on these concerns.

2. Definition

- 2.1 A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health agencies. It is also where a woman is not aware she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought for the duration of the pregnancy.
- 2.2 Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery. The birth may be unassisted whereby there are additional risks to the child and mother's welfare and long-term outcomes.
- 2.3 Child protection issues may arise where a pregnancy is disclosed late. For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy. Also, where there is no evidence of antenatal care in the UK or abroad.
- 2.4 It is possible that a mother not only conceals the pregnancy and birth, but also the baby's body, should the baby die. Concealed birth (including concealed still birth) represents a criminal offence, though enquiries into these circumstances should be conducted sensitively and with due regard to the context in which this takes place.
- 2.5 It is also recognised that there will be situations where a baby is not declared. It is an offence to not register the birth of a child whether born alive or stillborn under the birth registration and death act 1953. It could be seen as neglectful of the child if there is failure to seek the appropriate care either pre or post birth.

3. Reasons for Concealment

- 3.1 Studies have shown that late commencement of antenatal care is associated with teenage pregnancy, for a variety of reasons. These include not fully understanding the consequences and complications of risk factors in pregnancy, poor motivation to keep appointments, concealment or denial of pregnancy.
- 3.2 In some cases the woman or young girl may be truly unaware that she is pregnant until very late into the pregnancy. For example a young woman with a learning disability may not understand why her body is changing.
- 3.3 Denial may persist as a result of thinking that the problem will go away if it is ignored.
- 3.4 Due to stigma, shame or fear, concealment may be a deliberate means of coping with the pregnancy without informing anyone.
- 3.5 A woman or girl may conceal their pregnancy if it occurred as the result of sexual abuse, either within or outside the family, due to her fear of the consequences of disclosing that abuse.
- 3.6 A woman who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant.
- 3.7 A pregnancy may be concealed in situations of domestic violence. Domestic abuse is more likely to begin or escalate during pregnancy.
- 3.8 In some religions and cultures, a pregnancy outside of marriage may have life threatening consequences for the woman involved. In these instances, women have been known to conceal their pregnancy or 'disappear' to avoid bringing shame to the family.
- 3.9 'Freebirthing' is growing in popularity in the United States and has been reported in the UK (Society Guardian May 9th 2007). Freebirth is where a woman chooses to give birth alone. In some instances, the women were reported to engage in antenatal care, but others chose to avoid all antenatal care whatsoever.

4. Local Context

- 4.1 There is very little national or local research in relation to concealed pregnancies available and this had not been identified as a particular concern in London Borough of Enfield.

5. Implications and Indicators of a Concealed Pregnancy

- 5.1 The potential risk to a child through the concealment of a pregnancy is extremely hard to predict. One key implication for the pregnancy is that there is no obstetric history or record of antenatal care prior to the birth of the baby which can impact on the management of care. Some women may present late for booking (after 24 weeks of pregnancy) and these pregnancies need to be closely monitored to assess

future engagement with health professionals, particularly midwives and whether or not referral to another agency is indicated.

- 5.2 In relation to the child protection issues regarding concealed pregnancy, the focus is on the child regardless of whether unborn or born.
- 5.3 Research undertaken in other authorities has found that concealment appears to be reported equally across all ages. It is not just a teenage phenomenon.
- 5.4 Previous concealed pregnancy may also be regarded as an important indicator in predicting risk of a future pregnancy being concealed with a harmful outcome for the child.

Indicators

- 5.5 Research has identified the following indicators:
 - Previous termination, thoughts of termination and/or unwanted pregnancy.
 - Loss of a previous child (i.e. adoption, removal under Care Proceedings)
 - General fear of being separated from the child
- 5.6 There could be a number of reasons why women fear that they will be separated from their child. Research evidence suggests that substance-misusing women may avoid seeking help during pregnancy if they fear that this disclosure will inevitably lead to statutory agencies removing their child.
- 5.7 It may be important to consider the role of collusion within the family. In some national and local cases, the family appeared to encourage the concealment and the mother's own family were aware of the situation, and the pregnant daughter was allowed to develop high levels of privacy in the home.

6 Risks/Protection Issues

- 6.1 The reason for the concealment will be a key factor in determining the risk to the child and that reason will not be known until there has been a systematic multi-agency assessment.
- 6.2 The implications of concealment are wide-ranging. Concealment of a pregnancy can lead to a fatal outcome, regardless of the mother's intention.
- 6.3 Concealment may indicate ambivalence towards the pregnancy, immature coping styles and a tendency to dissociate, all of which are likely to have a significant impact on bonding and parenting capacity.
- 6.4 Lack of antenatal care can mean that any potential risks to mother and child may not be detected. It may also lead to inappropriate advice being given; such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy.
- 6.5 The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected.
- 6.6 Underlying medical conditions and obstetric problems will not be revealed.
- 6.7 An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery.

- 6.8 Other possible implications for the child arising from mother's behaviour could be a lack of willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth. Nirmal et al (2006) identify denial of pregnancy as a likely precursor of poor adaptation postpartum and highlights the need for increased monitoring in the postpartum period.
- 6.9 Where concealment is linked to alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently. There are also risks to the unborn baby from prescribed medications.
- 6.10 There may be risks to both mother and child if the mother has concealed the pregnancy due to fear of disclosing the paternity of the child, for example where the child has been conceived as the result of sexual abuse, or where the father is not the woman's partner

7 Where Suspicion Arises – Action to take

- 7.1 This section deals with actions to be taken by professionals when suspicion is aroused that a young woman/woman is concealing a pregnancy, by consistently denying that she is pregnant or where other evidence suggests pregnancy.
- 7.2 There is a need to balance the need to preserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. There will be a point at which the child's welfare overrides the mother's right to confidentiality. This is a relevant consideration even though the baby is in utero.
- 7.3 Where there is a strong suspicion that a pregnancy is being concealed, it may be necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained (refer to Section of the All London Child Protection Procedures). Every effort should be made by the person alerted to suspicion of concealed pregnancy to encourage the (young) woman to obtain medical advice. If the response shows that this is unlikely an early help form should be completed and forwarded to the SPOE, so that effective service responses may be co-ordinated.
- 7.4 Where anyone has such concerns they should contact anyone in another agency known to have involvement with the young/ woman so that a fuller assessment of the available information and observations can be made.
- 7.5 If concerns are such that an early help form is completed, it should be forwarded to the SPOE, the early help form will be made on the unborn child. If the mother is under 16, she will also be the subject of an early help form as there may also be a child protection concern or criminal offence to be investigated. (see flowchart)

8 When Concealment Is Revealed

- 8.1 Where a concealed pregnancy is identified, the key question is 'why has the pregnancy been denied / concealed? The circumstances leading to concealment of pregnancy need to be explored individually. A detailed multi-agency assessment should be undertaken (refer to appendix 2).
- 8.2 While midwifery services will be the primary agency involved with women after the concealment is revealed, either late in pregnancy or at the birth, any of the agencies may be the ones to whom the woman either discloses, or in whose presence labour commences. All agencies should ensure that information about the concealment is

shared with other relevant agencies, to ensure its significance is not lost and to ensure that potential future risks can be fully assessed and managed.

- 8.3 *'An early help form must always be made where there are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care, non-co-operation with necessary services, non compliance with treatment with potentially detrimental effects for the unborn baby'.*
- 8.4 In cases of full concealment followed by unassisted delivery, Children Social Services must always be informed and a full psychiatric assessment considered jointly by the agencies. Assessment should include the possible contribution of the painful reactivation of childhood trauma (Spielvogel & Hohener 1995).
- 8.5 Assessments should identify clear expectations of parents and should they fail to comply this would constitute a significant risk factor and point to the need to activate child protection processes and / or care proceedings.

9 Staff in Educational Settings

- 9.1 In many instances staff in educational settings may be the professionals who know a young woman best. Supportive, caring and non-judgmental pastoral support systems within schools can be extremely valuable in resolving problems at an early stage. It may be appropriate to engage the assistance of the Designated Senior Person for Child Protection in addressing these concerns.
- 9.2 Where there is significant evidence that a girl is pregnant despite repeated denial, such as:
- Increased weight or attempts to lose weight
 - Wearing uncharacteristically baggy clothing
 - Concerns expressed by friends
 - Repeated rumours around school
 - Uncharacteristically withdrawn or moody behaviour

Staff working in educational settings should try to encourage the pupil to discuss her situation, through normal pastoral support systems, as they would any other sensitive problem. However, where they still face total denial further action should be considered. Negotiating the early assistance of or referral to the School Nurse may be appropriate in these circumstances.

- 10.12 Education staff may often feel the matter can be resolved through discussion with the parents of the young woman or girl. However, this will need to be a matter of professional judgement and will clearly depend on individual circumstances including relationships with parents. It may be felt that the girl will not admit to her pregnancy because she has genuine fear about her parent's reaction, or there may be other aspects about the home circumstances that give rise to concern.
- 10.13 If education staff do engage with parents they need to bear in mind the possibility of parent's collusion with concealment. Whatever action is taken, whether informing the parents or involving another agency, the girl should be appropriately informed, unless there is a genuine concern that in so doing, the girl may attempt to harm herself or her unborn baby.
- 9.4 It will be beneficial to convene a multi-agency meeting to include the Education Welfare Officer, School Nurse and other appropriate professionals.
- 9.5 If there is a lack of progress in resolving the matter, either due to possible collusion

by the parent, or inaction by another agency, there should be a referral to Children social services.

- 9.6 Where there are significant concerns regarding the girl's family background or home circumstances, such as a history of abuse or neglect, a referral should be made to children social services.
- 9.7 Professionals who are in contact with girls not attending school should consider the possibility that pregnancy may be a cause for non-attendance.
- 9.8 When faced with significant evidence (as above) that a girl maybe pregnant, yet continues to deny this when asked, a referral should be made to so children social services.
- 9.9 As with any early help form completed and forwarded to the SPOE, the parents and the young woman should be informed, unless in so doing there would be significant concern for the young woman's welfare, or that of the unborn child.

10 Health

All health professionals should inform service users if they plan to complete an early help form, unless there are significant concerns for the child's welfare. There may be a concern that some service users will cease contact with the service or leave the area if they are informed that an early help form has been forwarded to the SPOE. In such circumstances the situation should be discussed with Children Social services to consider how the service user should best be approached

Midwives and Midwifery Services.

- 10.1 Women concealing their pregnancy are unlikely to present for maternity care. However, if an early help form is made by the GP or other health professional the midwife in particular has a unique opportunity to observe attitudes towards the foetus and identify potential problems during pregnancy, birth and the child's care.
- 10.2 If an appointment is made very late for antenatal care (after 24 weeks of pregnancy), the reason for this must be explored. Midwives and Obstetricians should consider whether a psychiatric referral is indicated.
- 10.2 If there is a cause for concern an early help form should be made to the SPOE. The young girl / woman must be informed that an early help form has been made unless there are significant child protection concerns. It may also be helpful to discuss the concerns with the Named Midwife for Child Protection
- 10.3 If a young girl/women arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, an early help form should always be made to SPOE, in the area where the woman resides.
- 10.4 If the baby arrives at the weekend/bank holiday/out of hours the contact should be made to the out-of hour's service for Children social services.
- 10.5 If the baby had been harmed in any way, or abandoned as a result of the mother's actions (or non-action), an early help form must be made to the SPOE and the Police must be informed immediately.
- 10.6 Midwives should ensure information regarding the concealed pregnancy is placed on the child's records, as well as the mother's records.

- 10.7 Following a concealed pregnancy or unassisted delivery, Midwives need to be alert to the level of professional engagement allowed by the mother (and her extended family), and of receptiveness to future contact from health professionals.
- 10.8 Midwives must be alert to the level of attachment behaviour demonstrated in the early postpartum period.
- 10.9 In cases of full concealment followed by unassisted delivery, a full psychiatric assessment should be considered.
- 10.10 With reference to 11.9, the baby should not be discharged until a strategy meeting has been held and relevant assessments undertaken.
- 10.11 The discharge summary from Maternity Service to the GP, Health Visitor child health must report if a pregnancy was concealed or booked late (after 24 weeks).

School Nurse

- 10.12 The School Nurse is well placed to work with school age girls who may be pregnant. Offering a confidential service, a step removed from school and with health expertise, the School Nurse may well be able to help a girl to accept that she needs support. If possible, having gained consent from the young person, it may be helpful to liaise with the G.P and Health Visitor to consider a way forward.
- 10.13 When faced with continued denial, the School Nurse should seek advice from the Named Nurse to determine whether a referral to Children social services may be appropriate.

GPs and Practice-employed Staff.

- 10.14 Women who are concealing are unlikely to present at GPs for pregnancy tests. However, they may present for other reasons. Generally, as a matter of good practice, in any female presenting with nausea or weight gain, the possibility of pregnancy should be considered and appropriate examination and investigation performed.
- 10.15 In some instances, women may be genuinely unaware they are pregnant, but in others, the woman may be determined to conceal the fact, and may be extremely reluctant to agree to a pregnancy test or examination. Where a G.P has significant reason to believe a woman is pregnant, but she refuses all attempts to persuade her to undertake further investigations, further action needs to be taken. This should include discussion with the Midwife, Health Visitor or School Nurse (as appropriate), any of whom may be able to pursue the matter further or refer on to Children social services. It may be helpful to discuss the concerns with the Designated (or Named) Doctor or Nurse for Child Protection.
- 10.16 Given that a previous concealed pregnancy indicates increased risk of further concealment, where this has been the case it should be highlighted within the summary in the G.P records.
- 10.17 The GP may initiate a psychiatric assessment or be asked to make a referral by a colleague.

Health Visitors

- 10.18 Health Visitors, in the course of their involvement with young families, will be aware of the circumstances of previous pregnancies, and bearing in mind the pre-disposing risk indicators referred to previously, need to be alert to the possibility that a woman may be concealing a pregnancy. If the Health Visitor believes a woman may be pregnant, she should encourage her to seek support
- 10.19 As an initial step it may be helpful to discuss the matter with the G.P and the Midwife to consider a way forward.
- 10.20 When faced with significant reason to believe a woman is pregnant, and yet in total denial, Health visitors should discuss their concerns with the Named Professional, to determine whether a referral to Children social services may be appropriate. An early Edinburgh Depression Screening (EPDS) may be indicated.

Professionals working in Mental Health and Learning Disability.

- 10.21 Mental illness, emotional problems, personality problems, a learning disability or substance misuse may all be contributory factors as to why some women conceal the fact that they are pregnant. There is also an increased likelihood that women using these services may have had previous children removed from their care.
- 10.22 Very occasionally, some women with learning difficulties may be unaware they are pregnant or else may be extremely fearful that their baby will be removed. The GP needs to be informed if there are suspicions that a woman with a learning disability might be pregnant.
- 10.23 Professionals working in Mental Health or with clients with learning difficulties may be well placed to resolve the matter, given the therapeutic relationship with the woman. However, in the face of determined denial, or where it is felt the woman or unborn child may be at risk of harm an early help form should be made to the SPOE.

Other Health Professionals.

- 10.24 All health professionals should give consideration to the need to make or initiate a referral for a mental health assessment at any stage of concern regarding a possible or proven concealed pregnancy.
- 10.25 A&E and Staff working in radiology departments: Staff working in these areas need to routinely ask women of child bearing age whether they might be pregnant. If suspicions are raised that a pregnancy may be being concealed this should be recorded and an appropriate note made to the referring physician or G.P.
- 10.26 All health professionals who provide help and support to promote children's health and development should be aware of the risk indicators and how to act on their concerns if they believe a woman may be concealing a pregnancy.

12 Children Social Services

- 12.1 When an early help form is made to the SPOE regarding a suspicion of concealment, it may be that the expectant mother will not have consented to the early help form, and may not know about it. Good practice, however, would require consent to disclose that information, unless doing so would place the child at risk of

- significant harm. The early help form will be made due to potential risk to the unborn child and/or the expectant mother, with particular attention if the mother is under 16.
- 12.2 The early help form to the SPOE should be made in the name of the young girl if under 16 years. A Child and Family Assessment will be considered to assess the needs of the young person and the unborn baby. When a young person under 16 is pregnant, there may be a criminal or child protection investigation to consider. If the woman thought to be pregnant is over 16, the early help form will be made in the name of the unborn baby and again, a Child and Family Assessment will be made to consider the needs of both unborn baby and mother. The SPOE should consider allocating the Child and Family Assessment to a worker with mental health expertise.
 - 12.3 Where the 'expectant mother' is under 16, initial approaches should be made confidentially to the young woman to discuss concerns regarding the potential unborn child. She should be provided with the opportunity to satisfy social workers she is not pregnant, by undertaking appropriate medical examination or investigation, or to begin to make realistic plans for the baby, including informing her parents.
 - 12.4 In the event the young woman refuses to engage in constructive discussion, and where parental involvement is considered necessary to address risk, the parent/main carer should be informed and plans made wherever possible to ensure the potential baby's welfare. Potential risks to the unborn child or to the health of the young woman would outweigh the young woman's right to confidentiality, if there was significant evidence that she was pregnant. If the first approach to her is made by an education or health professional and this leads to an early help form to the SPOE, a Social Worker may need to consider speaking to her without her parent's knowledge in the first instance. She should be encouraged to undergo a pregnancy test or medical examination to confirm whether she is pregnant or not.
 - 12.5 If the young person refuses to engage in a constructive discussion, Children's social services should inform her parents and continue to assess the situation with a focus on the needs/welfare of the unborn baby as well as the young person. In this situation, professionals will have very clear reasons to suspect pregnancy in the face of continuing denial and such a situation will require very sensitive handling. In this situation, the potential risks to the unborn child would outweigh the young person's right to confidentiality.
 - 12.6 Where the 'expectant mother' is over 16, every effort should be made to resolve the issue of whether she is pregnant or not. Clearly no woman can be forced to undergo a pregnancy test, nor any other medical examination, but in the event of refusal, social workers should proceed on the assumption that the woman is pregnant, until or unless it is proved otherwise, and endeavour to make plans to safeguard the baby's welfare at birth.
 - 12.7 A multi-agency meeting should be convened, involving GP, midwives and any other relevant agency to assess the information and to construct a plan. It may be appropriate to invite a representative from Mental Health Services (child or adult as appropriate) so that support, advice and/or consultation is available at an early stage.
 - 12.8 Where there are additional concerns, e.g. lack of engagement, possibility of sexual abuse, or substance misuse, the referral should be dealt with under child protection procedures (Section 47 investigation). It may be appropriate to convene a pre-birth child protection conference.

- 12.9 If a woman or young person has arrived at hospital, either in labour or following an unassisted birth, an early help form must be made to the SPOE.
- 12.10 A Child and Family Assessment will be started and a strategy meeting convened under Child Protection Procedures. An investigation under Section 47 of the Children Act should commence and will conclude with a decision about the need to convene a Child Protection Conference. The same analysis of risk should be applied to women who book late (after 24 weeks gestation), arrive in labour or following an unassisted delivery.
- 12.11 Where a baby has been harmed, has died or has been abandoned, the early help form will be passed on to the local Children social services team immediately and an investigation under Section 47 of the Children Act will commence immediately. The Police must be notified immediately.
- 12.12 Where the early help form is received out of hours, in relation to a baby born as the result of a concealed pregnancy, the Emergency Out of Hours Service will take steps to prevent the baby being discharged from hospital until a Child and Family Assessment has been undertaken. In normal circumstances this would be through a voluntary agreement, although clearly there could be circumstances in which it would be appropriate to consider an application for an Emergency Protection Order, or to seek the assistance of the Police in preventing the child from being removed from the hospital.
- 12.13 In undertaking a child and family assessment the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child, as well as all the other aspects of the Assessment Framework, as these will be one of the key factors in determining risk.
- 12.14 Following a child and family assessment it may be appropriate to refer the young girl/woman for psychological help. There clearly could be a number of issues for the young girl/woman which would benefit from psychological or psychiatric support. This might include Post Traumatic Stress Disorder, risk of postnatal depression, the impact if pregnancy was the result of abuse, the impact of denial of pregnancy, impact on parenting ability and emotional distress. A psychiatric assessment might be required in some circumstances; for example, if it is thought that the mother poses a risk to herself or to others. It may also be appropriate to consider a referral for the infant for psychological support such as to early year's services or CAMHS.

15. Future pregnancies

- 15.1 Where it is known there is a history of previous concealed pregnancy, an early help form must be made to the SPOE as soon as any subsequent pregnancy is known. Women who have already concealed a pregnancy are at a particular risk of doing so in the future. Children social services will convene a multi-agency strategy meeting and make a plan to address any potential risk within a future pregnancy. Sharing information openly will be a critical factor in safeguarding the unborn child and professionals will need to accept this may be without the consent of the mother concerned.

- 15.2 Only when the underlying reasons for a previous concealed pregnancy are revealed, explored and addressed, can the risk of future concealment be substantially reduced.
- 15.3 Following a concealed pregnancy where significant risk has been identified, Children social services should take the lead in developing a multi-agency contingency plan, to address the possibility of a future pregnancy. This will include a clearly defined system for alerting Children social services if a future pregnancy is suspected.
- 15.4 Where there is a Plan in place, it should be activated as soon as professionals become aware of a subsequent pregnancy.

Appendix 1 – Flowcharts

Appendix 2 – Adapted Framework for Assessment – Antenatal Assessment

Appendix 3 – Risk Indicators of concealed pregnancy

Appendix 4 – Research Evidence

Appendix 5 – Legal implications

Enfield Key Contacts

If you have any concerns about a child

Single Point of Entry (SPOE) 0208 379 5555

Intake & Assessment Team (Mon-Fri - 9am-5.pm) 020 8379 2507
Fax 020 8379 2498

Out of Office Hours

Emergency duty social work team 020 8379 1000

Police Child Abuse Investigation Team 020 8733 5070

Alcohol and Drug service

Enfield designated doctor 020 8375 2620
Enfield designated nurses

Chase Farm hospital

Named doctor 020 8375 2915
Named nurse 020 8216 5207

Named Midwife

North Middlesex University Hospital

Named Doctor 020 8887 2945
Named Nurse 020 8887 4093
Named Midwife 020 8887 4412

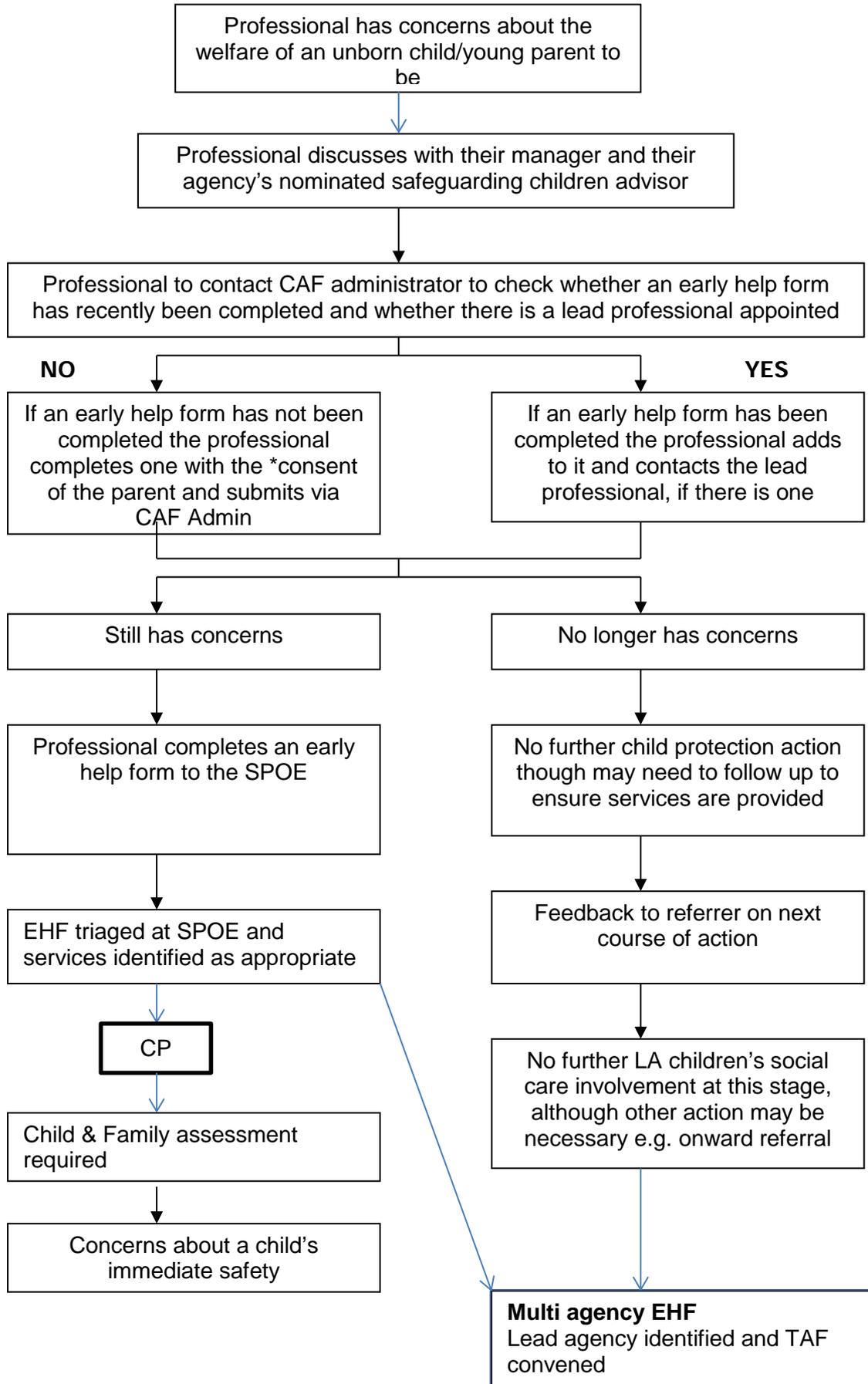
The Young Parents Project 020 8807 4691

CAMHS 020 8379 2000

Communication

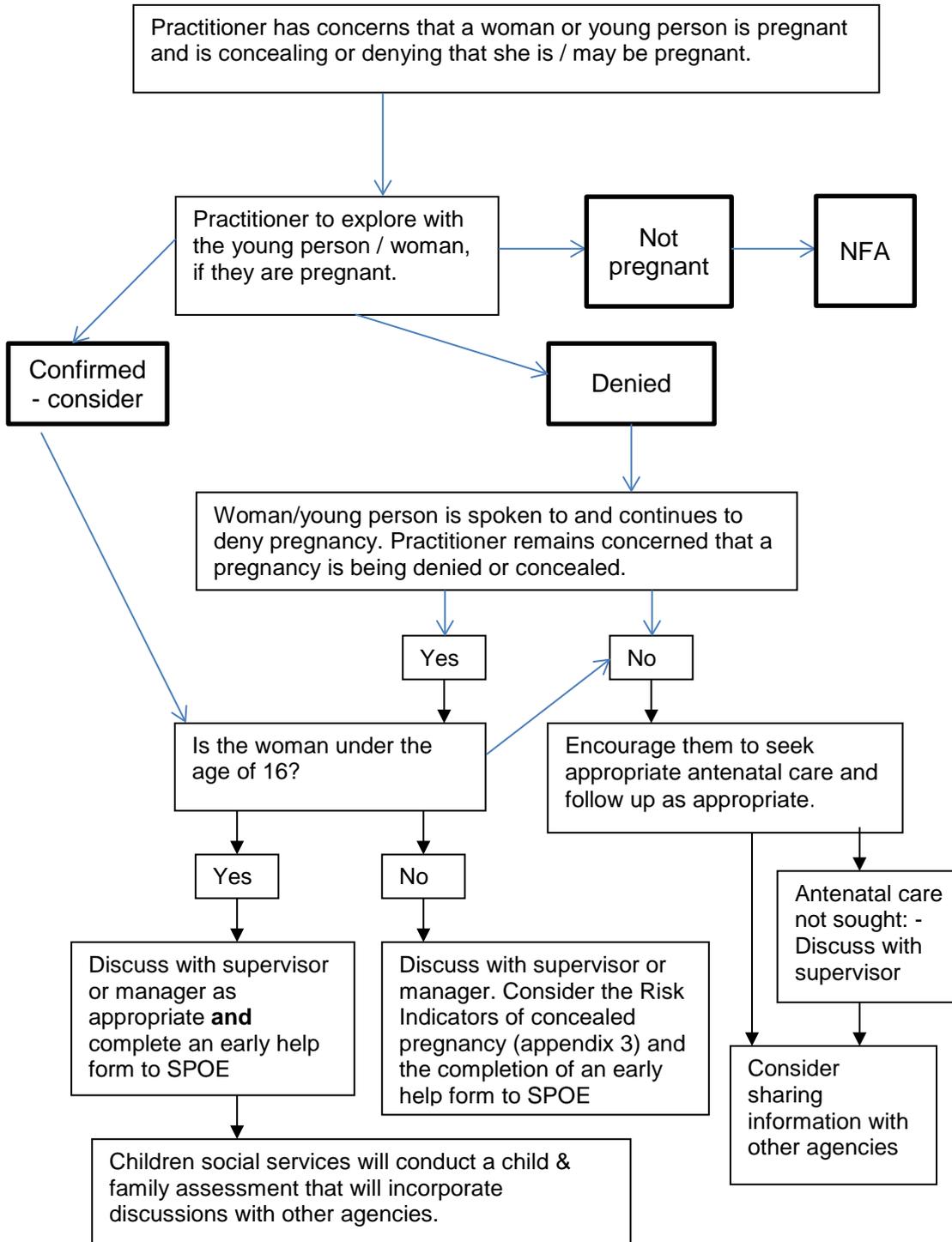
It is not sufficient to leave messages about a patient on voicemail or answer phones; all voicemails should leave a number that can be dialled and which will be answered by a social worker in person. Information must be left with the patient's Children's Services social worker, the duty worker or the relevant administrative officer and a record made of the person spoken to. Out of normal office hours, information should be passed to the emergency duty social worker. It should then be faxed to the relevant duty team the next working day.

Flowchart

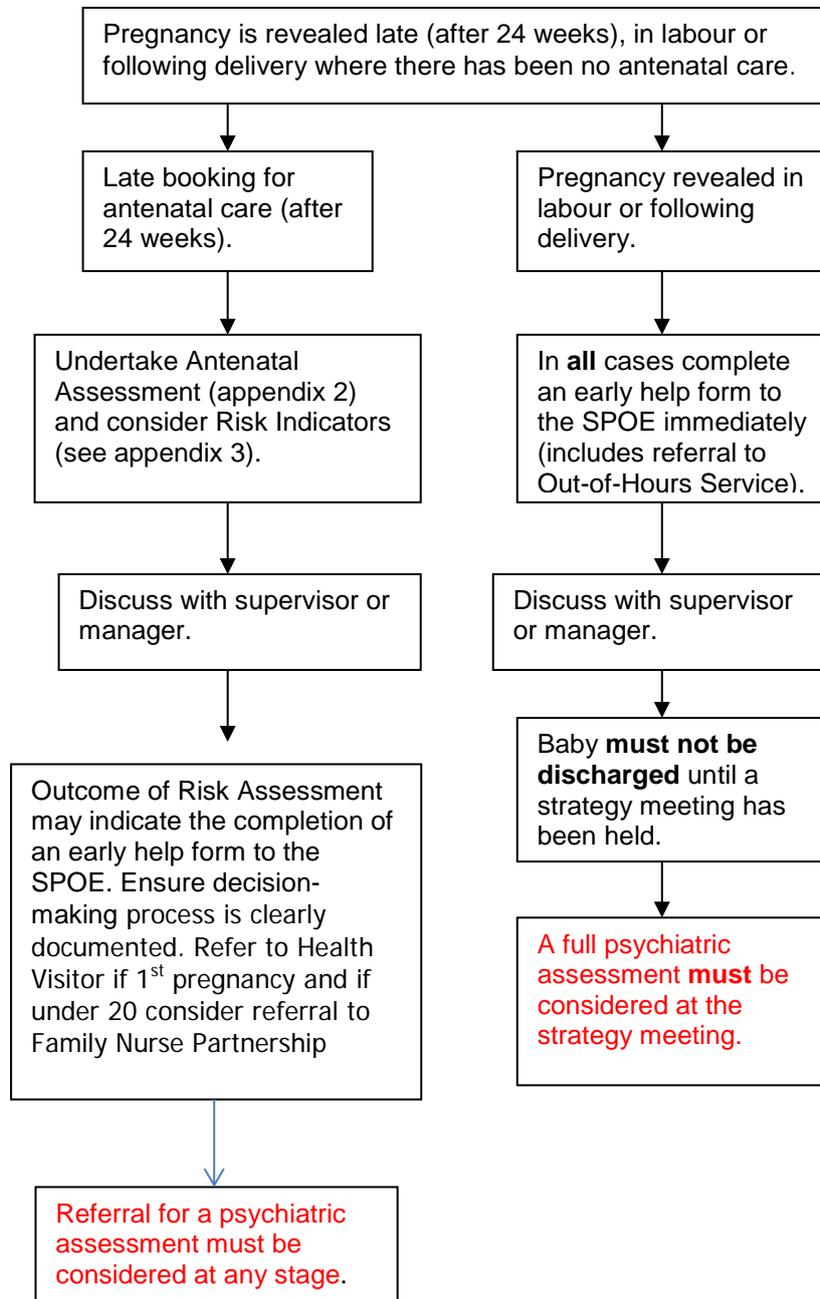


**If consent for referral is refused but the professional has CP concerns for the unborn or parent, the EHF should still be completed and submitted for CP consideration*

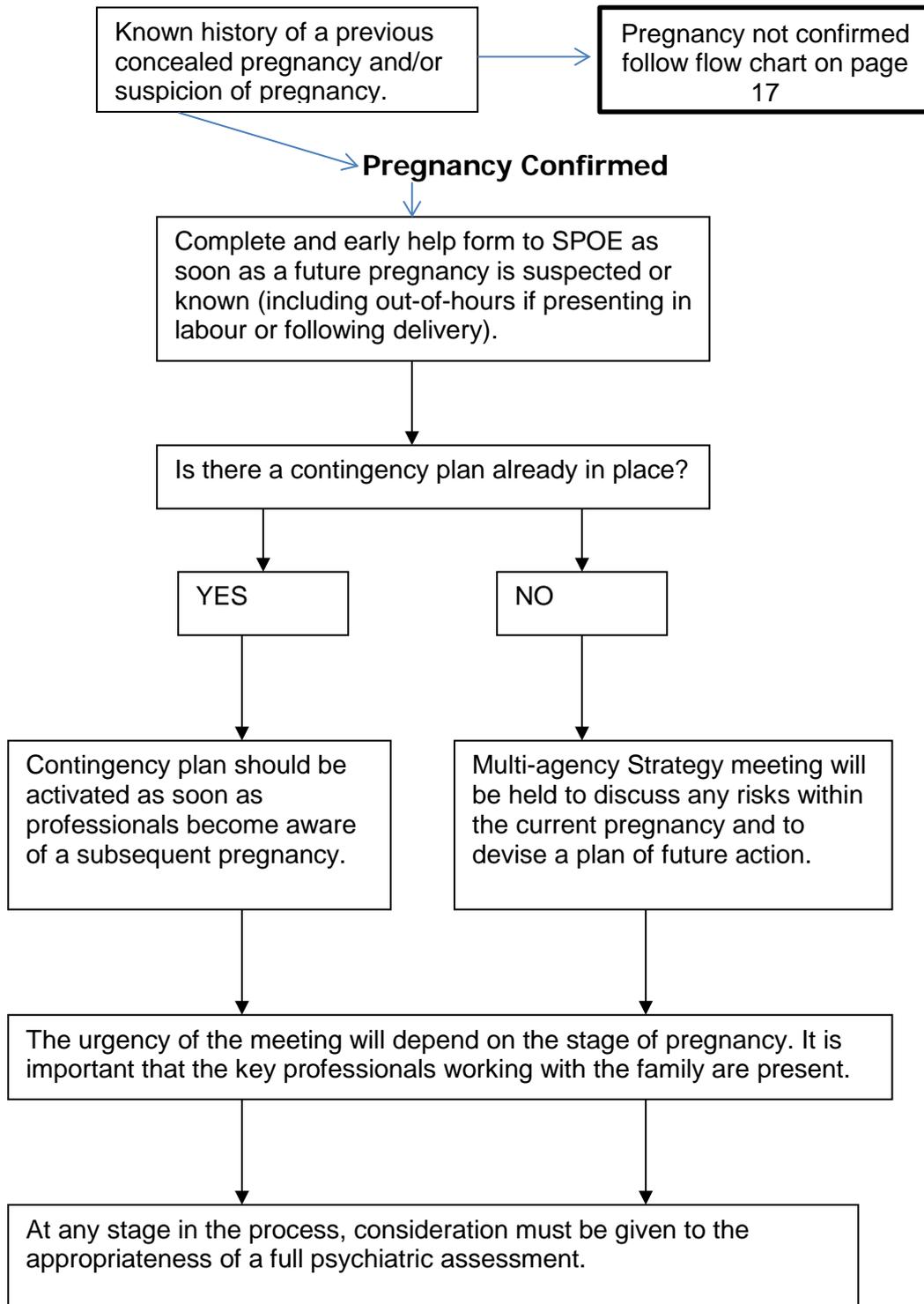
Suspicious arise that a pregnancy may be concealed or denied



Concealment is revealed.



Pregnancy when there has been a known concealed or denial of pregnancy in the past.



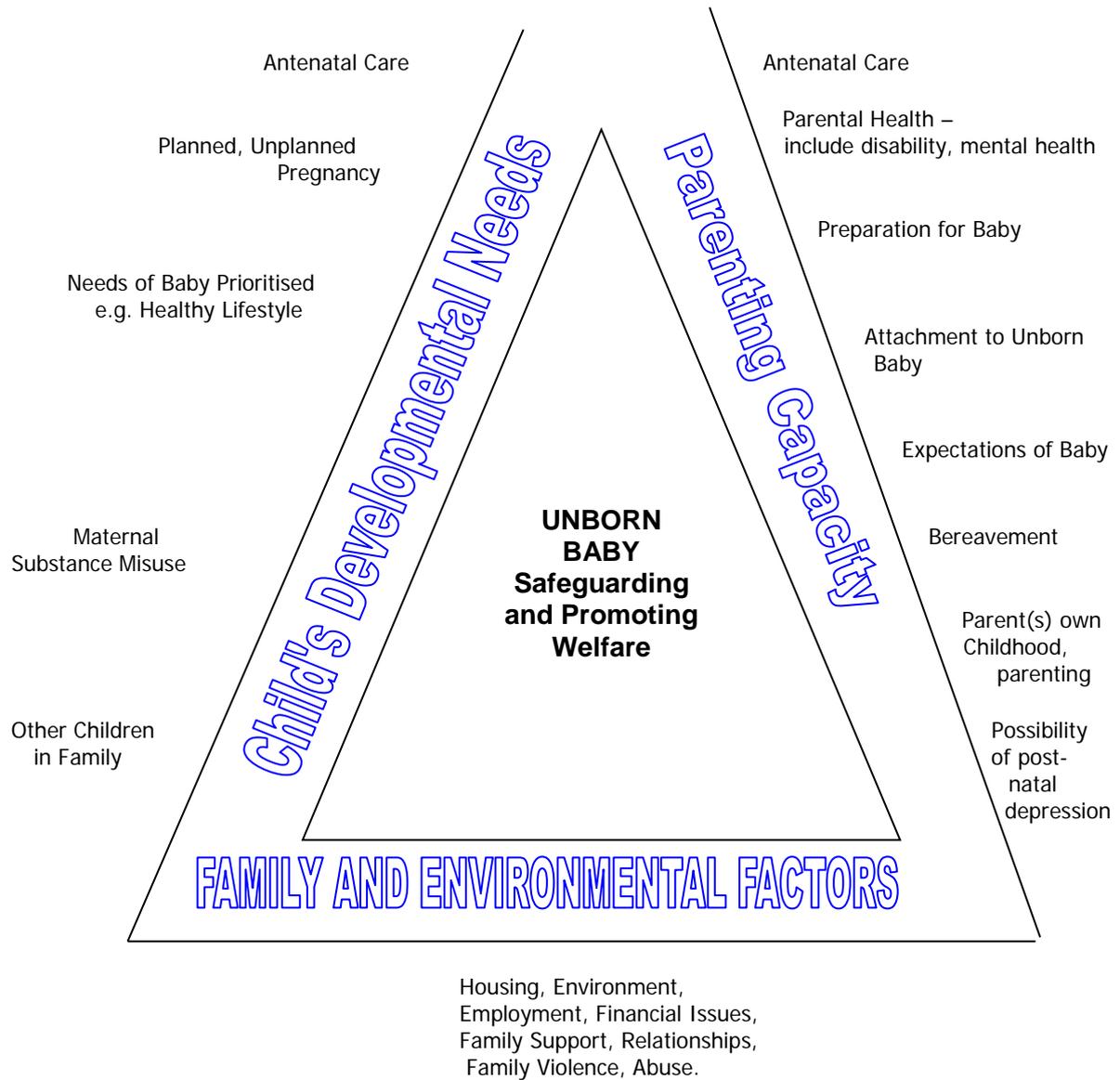
ADAPTED FRAMEWORK FOR ASSESSMENT ANTENATAL ASSESSMENT

Mother:

EDD:

Partner:

GP:



Consider the dimensions of the Framework for the Assessment of Children in Need and using the using the accompanying notes complete the sections on the reverse.

Unborn baby's developmental needs

Parent(s) capacity to respond to unborn baby's needs

It is important to be aware of the parent(s) strengths as well as any difficulties they are experiencing. Research shows that the following are most likely to affect parenting capacity: physical illness, mental illness, learning disability, substance/alcohol misuse, domestic violence, childhood abuse, history of abusing children.

Family and environmental factors

Summary & Action Plan.

Summary of your information; how will the information you have gathered impact on the unborn baby.

Risk assessment completed	YES/NO
Care plan completed	YES/NO
Referral to other agencies	YES/NO
If yes, which agency	
Signature.....	Date
Print Name.....	Designation
Work Base.....	Contact No.....

RISK INDICATORS OF CONCEALED PREGNANCY.

The indicators below can be used to highlight risk and vulnerability and to indicate which women may need additional multi-agency assessment and support.

Name	Date of Birth			
		Yes	No	No Evidence
Lack of pre-natal care/Late booker				
Previous concealed pregnancy.				
Irrational perceptions / fears about being pregnant.				
Lack of suspicion by family/partners/colleagues.				
Poor parenting experiences as a child.				
Effects of early sexual trauma ie victim of sexual abuse.				
Interpersonal problems with partners and/or family members.				
Domestic Violence.				
Anticipation of separation from forthcoming baby (including inability to cope or baby will be taken away).				
Emotional problems (need to clarify). <input type="checkbox"/>				
Loss of custody of previous child (ren).				
Presenting with abdominal disorder / pain.				
History of substance misuse. <input type="checkbox"/>				
Mental health difficulties including: Schizophrenia Depression Personality Disorder Learning Disability				
Previous rejection of a child.				
Previous Social Care involvement re: childcare, including child protection.				
Moving geographical area / address or country				
Poor relationships with Health Professionals.				
Files lost / untraced.				
History of not registering with a GP.				
Not attending health and / or developmental checks with existing child (ren).				
Thoughts of termination.				
Lack of information about the father of current pregnancy.				
Family collusion (mother/ daughter relationships).				
Inability to provide appropriately for child's needs.				
Inability to perceive child's needs.				
Language difficulties. Is an interpreter needed?				

Acknowledgement to Gill Earl, Consultant Nurse Safeguarding Children.

Analysis and Plan (continue overleaf as necessary)

Signed:

Date:

Copy to:

Research evidence

1. There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that women may have a variety of reasons for their behaviour.
2. Reder et al (1993) summarised thirty-five major child death inquiries and highlighted evidence of considerable ambivalence to or rejection of some of those pregnancies and a significant number with little or no antenatal care. Reder & Duncan (1999) reinforce their previous evidence in a follow-up study but also identified a small sub-group of fatality cases where mothers did not acknowledge that they were pregnant and failed to present for any antenatal care and the babies were born in secret. A Review of forty Serious Case Reviews (DH 2002) identified one death was significant to concealment of pregnancy. Earl (2000, Friedman et al (2005), Vallone & Hoffman, highlight that there is a well-established link between neonaticide – infanticide in the 24 hours following birth - and concealed pregnancy.
3. Nirmal et al (2006) identified a preponderance of concealed pregnancies during the winter months.
4. The DfES published a research report in 2006 that highlights links of child abuse to 'possession and witchcraft'. In some parts of the UK, this has been identified as a concern. A woman may become pregnant but conceal the fact for fear that the baby may be taken from her (Stobart 2006).
5. Although there is minimal evidence available, practitioners should remain alert to a future pattern of concealed pregnancies once one has been identified. To assess the longer-term prognosis for the child it is important to gain some understanding of what outcome the mother intended for the child i.e. did she hope it would survive?
6. There are four known studies that look at some of the psychological dimensions of concealed (or denied) pregnancy (Brezinka et al 1994, Earl et al 2000, Moyer 2006, Spielvogel & Hohener 1995). Moyer (2006) draws attention to research findings that the majority of women who are in denial about pregnancy or who have concealed the pregnancy from others typically leave hospital without a mental health assessment. The paper highlights that denial or concealment of pregnancy should be a 'red flag' and that for such women a full psychiatric assessment is indicated.
7. A small number of studies have attempted to identify how frequently the phenomenon of concealment occurs (Nirmal et al 2006, Wessel & Buscher 2002). These suggest that concealment (through to delivery) might occur in about 1:2500 cases. Following several Serious Case Reviews, Lincolnshire recognised the significance of concealed pregnancy and commissioned a piece of research (Earl et al 2000) and subsequently developed a set of risk indicators (see appendix).

Legal considerations.

1. UK law does not legislate for the rights of the unborn baby. In some circumstances, agencies or individuals are able to anticipate the likelihood of significant harm with regard to an expected baby. The fact that the law does not identify the unborn baby as a separate legal entity should not prevent plans being made and put into place to protect the baby from harm both during pregnancy and after the birth.
2. In certain instances legal action may be available to secure medical intervention to protect the health and well-being of the mother and thereby, the unborn child. This may arise in cases where the young/ woman lacks capacity due to mental illness (acute or chronic), learning difficulty, her young age or some other circumstance. The absence of support for intervention from parents or carers may be overcome by the use of legal intervention. These measures can be secured in an emergency by application to the High Court. It is only possible to make appropriate contingency plans and to ensure that the woman/girl is fully aware of the consequences of her actions. In such circumstances, legal advice should be sought.
3. Care proceedings cannot be instigated for an unborn child. They are not likely to provide a mechanism for intervening even where the mother is under 17 years. A child assessment order will require the pregnant young woman's agreement and the making of an interim care order will not transfer any rights to Children social services to override the wishes of the young woman in relation to medical help. It may however provide a solution where the problem can be addressed by removing her from abusive carers to a safe environment such as foster care.
4. If legal steps need to be taken to protect a newborn baby, Children social services will take the lead in consultation with London Borough of Enfield Legal Services. Acute medical services (maternity or A&E) may also need to seek urgent legal advice in order to safeguard the health of a woman in labour who does not cooperate with the medical intervention.

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