

CONCEALED PREGNACY

Please note that providers of health services, in particular those providing midwifery services, may have their own detailed agency specific guidance which should be read in conjunction with this guidance. All agencies should follow the Interagency Concealed Pregnancy Guidelines.

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1. PURPOSE AND DEFINITION

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. The guidance should be applied in conjunction with the LSCB Procedures with particular reference to the Information Sharing Procedure, and the Referrals Procedure

A concealed pregnancy is where:

- An expectant mother is aware that she is pregnant but does not tell any professionals; or
- An expectant mother tells a professional but conceals the fact that she is not accessing antenatal care; or
- An expectant mother tells another person or persons and they conceal the fact from all health agencies.

The concealment of pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the foetus (unborn child) and the mother. While concealment by its nature limits the scope of professional help, experience shows that better outcomes can be achieved by co-ordinating an effective interagency approach once the fact of the pregnancy is established. This will also apply to future pregnancies where there has been a previous concealed pregnancy. In some cases, pregnancies may be concealed until or after delivery, when particular attention should be given to safeguarding the child's welfare, and indeed to the wellbeing of the mother. For the purpose of this guidance a pregnancy will not be considered to be concealed until after 24 weeks.

In some cases, a woman may be unaware that she is pregnant until late in the pregnancy due to a learning disability. Concealment may occur as a result of stigma, shame or fear because the pregnancy may be the result of incest, sexual abuse, rape or as part of a violent relationship. It is important to note that pregnancies can be concealed by women of all ages and that this issue is not limited to teenagers.

2. RISKS

The potential risks to a child through the concealment of a pregnancy are wide ranging and difficult to predict. One key implication is that there is no obstetric history or record of antenatal care prior to the birth of the baby. 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. In a case of a denied pregnancy the effects of going into labour and giving birth can be traumatic.

Possible implications / outcomes:

- Concealment of a pregnancy can lead to a fatal outcome (for both mother and/or child), regardless of the mother's intention.
- Concealment may indicate uncertainty 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.
- Lack of antenatal care can mean that any potential risks to mother and child are not detected. It may also lead to inappropriate advice being given, including potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy. Underlying obstetric problems will not be revealed.
- The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected.
- An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the birth.
- Lack of maternal willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth could lead to neglect.
- Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently, including withdrawal.
- There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community.

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. The reason for the concealment will be a key factor in determining the risk to the child and therefore this must form an essential part of the assessment.

3. ADDITIONAL RISK FACTORS

If any of the following risk factors are identified during a pregnancy, a referral to Children's Social Care may be appropriate in order that a multi-agency assessment of risk can be determined:

- Children under the age of 13 (a referral is required in all circumstances where the child is under 13 or conceived prior to the child's 13th birthday).
- Children between the ages of 13 and 16 years.
- Misuse of drugs/alcohol by the pregnant woman (or partner).
- Mother not thought to be able to care for the child.
- Unable to provide for herself or her baby.
- Concerns around Domestic Violence and Abuse.
- Suffering from Learning Disabilities/Physical Disabilities where she is unable to care/provide for the child and has little or no support.

All decisions should be documented, with reasons, including any decision not to make a referral to Children's Social Care.

4. INDICATORS

- Previous concealed pregnancy is an important indicator in predicting risk of a future pregnancy being concealed.
- Previous termination of pregnancy, 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.

Expectant mothers who are misusing substances may avoid seeking help during pregnancy if they fear that this disclosure will inevitably lead to statutory agencies removing their child. It may be important to consider the role of collusion within the family.

5. PROTECTION AND ACTIONS – WHERE SUSPICION ARISES

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.

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. See section on Information Sharing. Every effort should be made by the person alerted to suspicion of concealed pregnancy to encourage the woman to obtain medical advice. If the response shows that this is unlikely referral should be made to Children's Social Care so that effective service responses may be coordinated.

If concerns are such that a Child Protection referral (see the Referrals Procedure), needs to be made to Children's Social Care, the referral will be made on the unborn child. If the mother is under 16, she will also be the subject of a referral as there may also be a criminal offence to be investigated.

All professionals should follow the Referrals Procedure process as well as this section.

The reasons for the concealment will not be known until a pre-birth assessment has been carried out. Whenever there is any concern over the mental health of the pregnant girl or woman, then a mental health assessment should be sought as soon as possible.

6. WHEN CONCEALMENT IS REVEALED

In some circumstances, agencies or individuals are able to anticipate the likelihood of Significant Harm with regard to an expected baby which must be addressed as soon as the pregnancy is confirmed to maximise time for full assessment, enabling a healthy pregnancy and providing support to parents so that (where possible) they can provide safe care.

The circumstances leading to concealment of pregnancy need to be explored individually as there may be potentially serious child protection outcomes as a result of a concealed pregnancy and a detailed interagency assessment should be undertaken. 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.

Where the girl/woman does not speak English as a first language an interpreter must always be sought. It is not appropriate to use family members to translate as this could put the girl/woman at risk of harm.

While midwifery services will be the primary agency involved with the woman after the concealment is revealed, other agencies/ services could be the first to identify a concealed pregnancy or receive a disclosure.

All agencies should ensure that information about:

- **The pregnancy is shared directly with midwifery services; and**
- **The concealment is shared with other relevant agencies**

A referral to Children's Social Care must always be considered 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. This may ultimately be effectively managed through the Single Assessment process.

If it is known that concealment of pregnancy is under duress or there is known domestic abuse, a risk assessment should determine whether this meets the threshold for a referral to Multi Agency Risk Assessment Conference (MARAC).

7. AGENCY ACTIONS

All professionals should follow the process as highlighted above in Protection and Actions section above. However, professionals should also follow the section below as relevant to their role.

STAFF IN EDUCATIONAL SETTINGS

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 school's Child Protection Coordinator in addressing these concerns.

Staff in educational settings may become concerned that a girl is pregnant despite repeated denial, as a result of:

- Increased weight or attempts to lose weight.
- Wearing uncharacteristically baggy clothing.
- Concerns expressed by friends.
- Repeated rumours around school.
- Uncharacteristically withdrawn or moody behaviour.

In these circumstances, staff 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.

Education staff may feel the matter can be resolved through discussion with the parent of the young woman/girl or other agencies already involved. 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 parents' reaction, or there may be other aspects about the home circumstances that give rise to concern. 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.

It will be beneficial to convene a multi-agency meeting to include the Education Welfare Service, School Nurse and other appropriate professionals.

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 the MASH.

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 the MASH.

Professionals who are in contact with girls not attending school should consider the possibility that pregnancy may be a cause for non-attendance.

HEALTH

Where possible, Health professionals should inform the service users, if there are significant concerns for the child's welfare, and they plan to refer to the MASH. There may be a concern that some service users will cease contact with the service or leave the area if they are informed that a referral has been made to. In such circumstances the

situation should be discussed with the Named Nurse or Midwife for the relevant health service, and the MASH to consider how the service user should best be approached.

MIDWIVES AND MIDWIFERY SERVICES

Women concealing their pregnancy are unlikely to present for pregnancy tests. However, if a referral 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.

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 always consider whether there is a need for a referral to other agencies such as Mental Health Services and ensure the use of routine enquiry into domestic abuse.

If there is a cause for concern, advice can be sought from the Named Midwife for Northern Lincolnshire and Goole NHS Foundation Trust, and a referral should be made to the MASH. The young girl / woman must be informed that the referral has been made, unless there are significant reasons not to do so, e.g. she may abscond.

If a young girl/woman arrives at the hospital in labour or following an unassisted delivery, and has not been booked with maternity services locally (or in their own locality if they do not reside in this area), a referral should always be made to Children's Social Care in the area where the woman resides.

If the baby arrives at the weekend/bank holiday/out of hours the contact should be made to the out of hours service for Children's Social Care.

If the baby had been harmed in any way or abandoned as a result of the mother's actions (or non-action), a referral must be made to the MASH and the Police must be informed immediately.

Midwives should ensure information regarding the concealed pregnancy is placed on the child's records, as well as the mother's records.

Following a concealed pregnancy or unassisted delivery, Midwives need to be alert to the level of professional engagement that will be necessary for the mother (and her extended family), and of the receptiveness to future contact from health professionals.

Midwives must be alert to the level of attachment/behaviour between mother and child demonstrated in the early postpartum period.

In cases of full concealment followed by unassisted delivery, a full psychiatric/psychological assessment should be considered.

In the cases of full concealment, the baby should not be discharged from hospital until a multi-agency / strategy meeting has been held and relevant assessments undertaken.

The Discharge summary from Maternity Service to Primary Care and Health Visiting must report if a pregnancy was concealed or booked late (after 24 weeks).

SCHOOL NURSING

The School Nurse may be well placed to identify and work with school age girls who may be pregnant. Their ability to offer a confidential service, within, but not employed by, the young person's school and with health expertise, the School Nurse may be able to help a girl to accept that she needs support. The School Nurse should liaise closely with the Consultant Midwife for Teenage Pregnancy in order to support the young person having gained consent from the young person. However, when faced with continued denial, the School Nurse should seek advice from the Named Nurse for Safeguarding Children in Children's Health Provision/ Named Midwife for North Lincolnshire and Goole NHS Foundation Trust to determine whether a referral to the MASH may be appropriate. It is important to note that if there is no consent or continued denial the practitioner must refer to the MASH in respect of safeguarding not only the school age child but also her unborn child.

GPS AND PRACTICE EMPLOYED STAFF

Women who are concealing are unlikely to present at GPs for pregnancy tests. However, they may present for other reason. As a matter of good practice, the possibility of pregnancy should be a prime consideration for GPs where nausea/vomiting is a key presenting symptom in a female patient who is of an age/development where sexual activity is possible. Appropriate examination and investigations should be performed.

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 GP 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. A discussion with the Designated Nurse for Named Midwife or Named GP for Safeguarding Children and liaison with the Midwife, Health Visitor or School Nurse (as appropriate) should take place. Where there are concerns about the potential welfare of the unborn child the GP should refer to the MASH.

Given that a previous concealed pregnancy indicates increased risk of further concealment, where this has been the case it should be documented within the GP records.

The GP may initiate a psychiatric assessment or be asked to make a referral by a colleague.

HEALTH VISITORS

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 predisposing 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.

As an initial step it may be helpful to discuss the matter with the Named Nurse for Safeguarding Children, GP and liaise with the Midwife to consider a way forward.

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 Nurse to determine whether a referral to the MASH may be appropriate.

MENTAL HEALTH AND LEARNING DISABILITY SERVICES

Professionals working in mental health and learning disability may be likely to be involved with a woman who is concealing a pregnancy. 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. If any professional working within these services identifies, or suspects a concealed pregnancy, they should seek to discuss this with their client, as appropriate, and contact their client's GP and midwifery services.

CHILDREN'S SOCIAL CARE

CONSENT TO REFERRAL

When a referral is made to the MASH regarding a suspicion of concealment, in particular where another professional believes the woman is denying a pregnancy, it is possible that the expectant mother will not have consented to the referral or may not be aware. Good practice would require consent to, or the woman being made aware of the referral, unless doing so would place a recently born baby at risk of significant harm. It may not have been possible for referring agencies to seek consent for referral if there are fears the pregnant young person/woman may disengage/ go missing if made aware of plan to refer.

REFERRALS WHERE 'EXPECTANT MOTHER' IS UNDER 16 (18 WITH ADDITIONAL VULNERABILITIES)

Referrals will be made due to potential risk to the unborn (or recently born) child and in respect of the mother if she is under 16, (or 18 if has additional vulnerabilities).

The referral to the MASH should be made, and recorded, in the name of the young girl if under 16 years (or 18 if there are additional vulnerabilities). An assessment of the needs of the young person and the unborn baby should be considered. When a young person under 16 is pregnant, there may be a criminal or child protection investigation to consider.

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.

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 a young person under 16 is thought to be pregnant but denying it, or concealing it, there could be many reasons for this. If the first approach to her is made by an education or health professional and this leads to a referral to the MASH, 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.

REFERRALS WHERE 'EXPECTANT MOTHER IS OVER 16

If the woman thought to be pregnant is over 16, the referral will be made in the name of the unborn baby and again, an Initial Assessment should be undertaken to consider the needs of both unborn baby and mother. The MASH should consider allocating the Initial Assessment to a worker with mental health expertise. If the case does not meet thresholds for statutory intervention, then all efforts should be made to gain consent for a Single Assessment referral. See the Child Concern Model (see NEL Together for All – Thresholds of Need 2019)

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.

IN ALL CASES

A multi-agency meeting should be convened, involving GP, midwives, Named Nurse/ Midwife, 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.

Where there are additional concerns, e.g. lack of engagement, possibility of sexual abuse, domestic abuse or substance misuse, the referral should be dealt with under child protection procedures. It may be appropriate to convene a pre-birth child protection conference.

An unborn child has no legal standing. Professionals cannot force an expectant mother to have any medical intervention at birth, unless she is deemed not to have Capacity. 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.

If a woman or young person has arrived at hospital, either in labour or following an unassisted birth, a referral must be made to the MASH. A referral should be initiated, and a strategy meeting convened under Child Protection Enquiries.

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.

Where a baby has been harmed or has been abandoned, the referral should be made to the MASH immediately and an investigation under Section 47 of the Children Act should commence immediately. The Police must be notified immediately.

Where the referral is received out of hours, in relation to a baby born as the result of a concealed pregnancy, the Out of Hours Service should take steps to prevent the baby being discharged from hospital until an assessment of risk 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.

In undertaking an 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.

Following an 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.

POLICE

The Police will be notified of any Child Protection Enquiries made by Children's Social Care following a concealed pregnancy.

Consideration will be given to whether a joint investigation is needed. This will be dependent upon whether an offence may have been committed or if the child (mother or baby) has suffered or is at risk of significant harm.

If a child has been harmed, has died or been abandoned, child protection procedures will apply and a joint investigation will be conducted with Children's Social Care.

8. FUTURE PREGNANCIES

Where it is known there is a history of previous concealed pregnancy, a referral must be made by the practitioner to Children's Social Care 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's Social Care may 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.

9. LEGAL CONSIDERATIONS

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.

NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN PARTNERSHIP

In certain instances, legal action may be available to secure medical intervention to protect the health and wellbeing 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. 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.

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's Social Care 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.

If legal steps need to be taken to protect a new-born baby, Children's Social Care will take the lead in consultation with North East Lincolnshire Council Legal Services.

Acute medical services (maternity or A&E) may also need to seek urgent legal advice in order to safeguard the health of the woman in labour who does not cooperate with the medical intervention. 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.

Additional guidance and advice will be required if it found that the mother may be a victim of trafficking and does not have legal status within the UK. Children's Social Care and the Police are classed as 'first responders' for making a referral to the National Referral Mechanism (NRM) to provide support and decision making.