



**Child protection
good practice guide**

Concealed pregnancy and birth



**WEST
SUSSEX
LOCAL
SAFEGUARDING
CHILDREN
BOARD**



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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 Sussex Child Protection and Safeguarding Procedures, with particular reference to sharing information (Section 2) and Pre-birth Child Protection Procedures (Section 8.20).

1.3 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 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. 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 well being of the mother.

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 may also be where a woman appears genuinely 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.

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 as the focus is on the child regardless of whether unborn or born.

2.4 For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy.

3 Reason for concealment – research evidence

3.1 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.

3.2 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. They also draw attention to 'the meaning of the child'. 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.

3.3 Studies have shown that late commencement of antenatal care may be a feature of 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.

3.4 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.

3.5 Denial may persist as a result of thinking that the problem will go away if it is ignored.

3.6 Due to stigma, shame or fear, concealment may be a deliberate means of coping with the pregnancy without informing anyone.

3.7 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.

3.8 A woman who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant.

3.9 There have been cases where the 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.

3.10 A pregnancy may be concealed in situations of domestic violence. Domestic abuse is more likely to begin or escalate during pregnancy.

3.11 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.

3.12 '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.

3.13 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).

3.14 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?

3.15 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.

4 National and 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 West Sussex prior to 2005. 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).

4.2 As far as is known, the majority of babies born of concealed pregnancy are healthy and go home with their mothers. However, little is known about the long-term outcomes for children and families of concealed or late booking pregnancies.

As from January 2007, data is being collected across all West Sussex Health Trusts in relation to late bookings for antenatal care, concealed pregnancies and deliveries.

5 Implications 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 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.

Research undertaken in other authorities has found that concealment appears to be reported equally across all ages. It is not just a teenage phenomenon.

Nirmal et al (2006) identified a preponderance of concealed pregnancies during the winter months.

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.

5.2 Research also identified the following indicators.

- Previous termination, thoughts of termination and/or unwanted pregnancy.
- Loss of a previous child (ie. adoption, removal under Care Proceedings)
- General fear of being separated from the child

5.3 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.

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 and 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 a result of 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

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 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 2 of the Sussex Child Protection and Safeguarding 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 referral should be made to CYPS so that effective service responses may be coordinated.

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 a Child Protection referral needs to be made to Children and Young People Services (CYPS), 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.

8 When concealment is revealed

8.1 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. Such circumstances should be addressed as early as possible to maximise time for full assessment, enabling a healthy pregnancy and supporting parents so that (where possible) they can provide safe care.

8.2 Where a concealed pregnancy is identified, the key question is 'why has the pregnancy been denied / concealed? Referring to research and the commentary above, some effort should be made to identify likely reasons for the concealment. The circumstances leading to concealment of pregnancy need to be explored individually.

8.3 Earl et al's study (2000) concluded that there are '*potentially serious child protection outcomes for the child as a result of a concealed pregnancy*' and that a detailed multi-agency assessment should be undertaken (refer to appendix 2).

8.4 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.

8.5 *'A referral to Children and Young People's Service (CYPS) 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' (8.20.4 Sussex Child Protection and Safeguarding Procedures).

8.6 In cases of full concealment followed by unassisted delivery, CYPS 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).

8.7 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.

9.3 Education staff may often feel the matter can be resolved through discussion with the parent 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.

If education staff do engage with parents they need to bear in mind the possibility of parents 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 and Young People's Service (CYPS).

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 CYPS.

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 CYPS.

9.9 As with any referral to CYPS, 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

PCTs are responsible for commissioning of acute and community health services and for providing health services in hospital and community settings. They will have an important role to play in developing local protocols and ensuring staff are alert to potential indicators of concealed pregnancy.

All health professionals should inform service users if they plan to refer to CYPS 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 a referral has been made to CYPS. In such circumstances the situation should be discussed with CYPS to consider how the service user should best be approached.

Midwives and Maternity Services

10.1 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 (refer also to Section 11).

School Nurse / School and Family Health Advisor.

10.2 The School Nurse / Advisor 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.

When faced with continued denial, the School Nurse should seek advice from the Named or Designated Nurse to determine whether a referral to CYPS may be appropriate.

GPs and practice-employed staff.

10.3 Clearly 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.

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.

10.4 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 CYPS. It may be helpful to discuss the concerns with the Designated (or Named) Doctor or Nurse for Child Protection.

10.5 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.

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

Health Visitors

10.7 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

10.8 As an initial step it may be helpful to discuss the matter with the G.P and the Midwife to consider a way forward.

10.9 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 / Designated Nurse / Doctor, to determine whether a referral to CYPS may be appropriate. An early Edinburgh Depression Screening (EPDS) may be indicated.

Professionals working in mental health and learning disability

10.10 For a variety of reasons, professionals in these services may be more likely to be involved with a woman who is concealing a pregnancy than other agencies. 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.

10.11 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.

10.12 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, a referral should be made to CYPS.

Other Health professionals

10.13 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.

10.14 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 GP.

10.15 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.

11 Midwives and Midwifery Services

11.1 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.

11.2 If there is a cause for concern a referral should be made to CYPS. The young girl / woman must be informed that the referral has been made, unless there are significant child protection concerns.

11.3 If a young girl/women arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, a referral should always be made to CYPS in the area where the woman resides.

11.4 If the baby arrives at the weekend/bank holiday/out of hours the contact should be made to the out-of hours service for CYPS.

11.5 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 CYPS and the Police must be informed immediately.

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

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

11.8 Midwives must be alert to the level of attachment behaviour demonstrated in the early postpartum period.

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

11.10 With reference to 11.9, the baby should not be discharged until a strategy meeting has been held and relevant assessments undertaken.

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

12 Children and Young People Services

12.1 When a referral is made to CYPS regarding a suspicion of concealment, it may be that the expectant mother will not have consented to the referral, 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 referral 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. (For guidance, see Section 2 Sussex Child Protection and Safeguarding Procedures, Information Sharing and Confidentiality).

12.2 The referral to CYPS should be made in the name of the young girl if under 16 years. An Initial 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 referral will be made in the name of the unborn baby and again, an Initial Assessment will be made to consider the needs of both unborn baby and mother. CYPS should consider allocating the Initial 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.

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 CYPS, 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.

If the young person refuses to engage in a constructive discussion, CYPS 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.

12.4 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.

12.5 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.

12.6 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.

12.7 An unborn child has no legal standing. Law cannot force an expectant mother, to have any medical intervention at birth unless she is deemed not 'of sound mind'. 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.

12.8 If a woman or young person has arrived at hospital, either in labour or following an unassisted birth, a referral must be made to local Children's Social Care.

An Initial 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.

12.9 Where a baby has been harmed, has died or has been abandoned, the referral will be passed on to the local CYPS team immediately and an investigation under Section 47 of the Children Act will commence immediately. The Police must be notified immediately.

12.10 Where the referral 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 an Initial 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.

12.11 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.

12.12 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.

13 Police

13.1 The Police will be notified of any Child Protection inquiries made by Children and Young People Services (CYPS) following a concealed pregnancy.

13.2 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 is at serious risk of significant harm.

13.3 If the child has been harmed, has died or been abandoned, child protection procedures will apply and a joint investigation will be conducted with the relevant CYPS team.

14 Other Local Safeguarding Children Board (LSCB) agencies

14.1 All professionals from statutory and voluntary agencies who provide services to young people and women of child bearing age, should be aware of the risk indicators of concealed or denial of pregnancy and how to act on these concerns.

15 Future pregnancies

15.1 Where it is known there is a history of previous concealed pregnancy, referral must be made to Children & Young People's Service 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. CYPS 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, CYPs 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 CYPs if a future pregnancy is suspected.

15.4 Where there is a known Plan in place, it should be activated as soon as professionals become aware of a subsequent pregnancy.

16 Legal considerations

16.1 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.

16.2 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.

16.3 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 CYPS 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.

16.4 If legal steps need to be taken to protect a newborn baby, CYPS will take the lead in consultation with West Sussex County 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.

Appendix 1

References

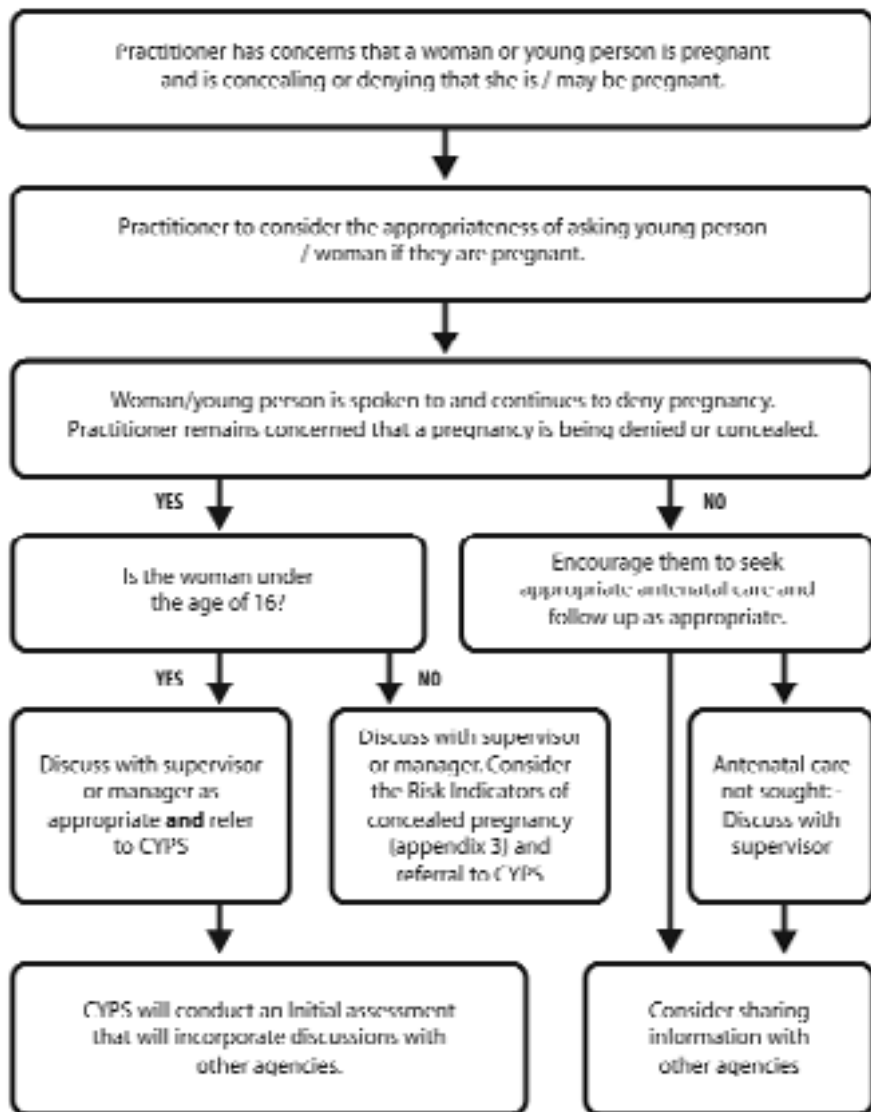
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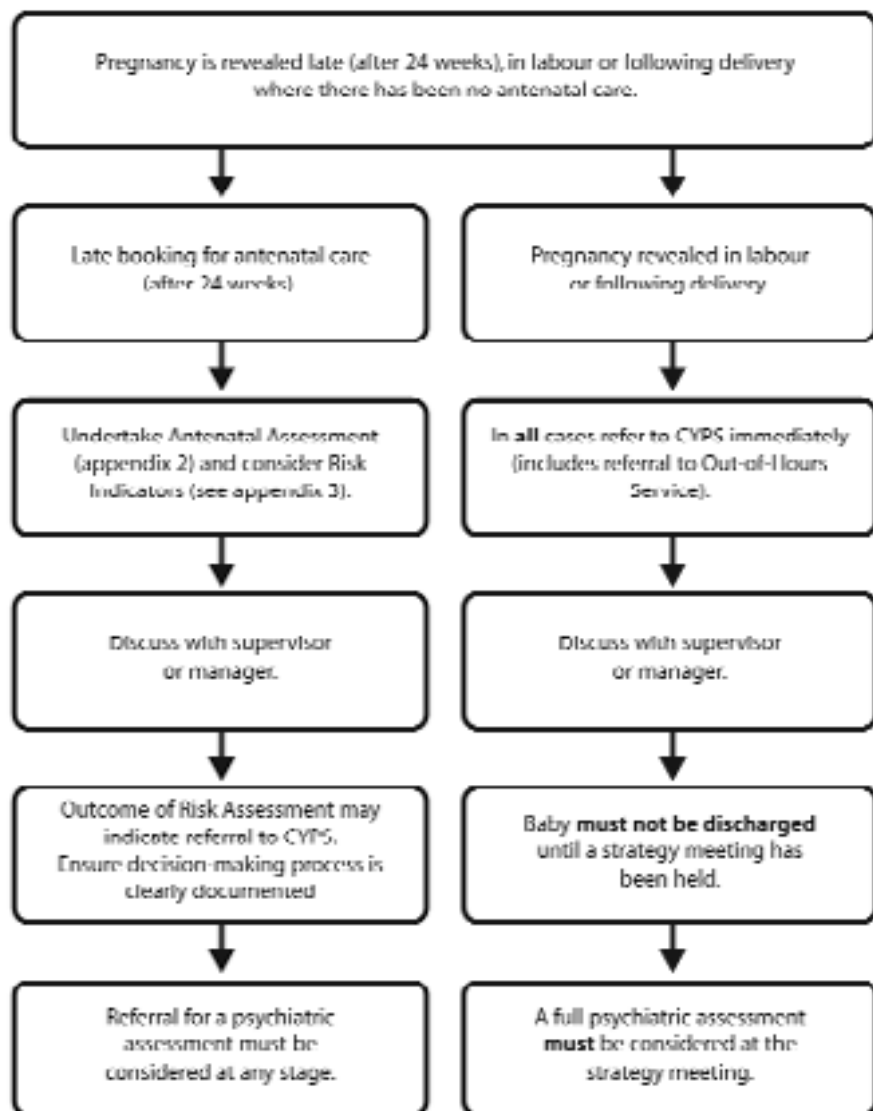
Appendix 2

Flowcharts

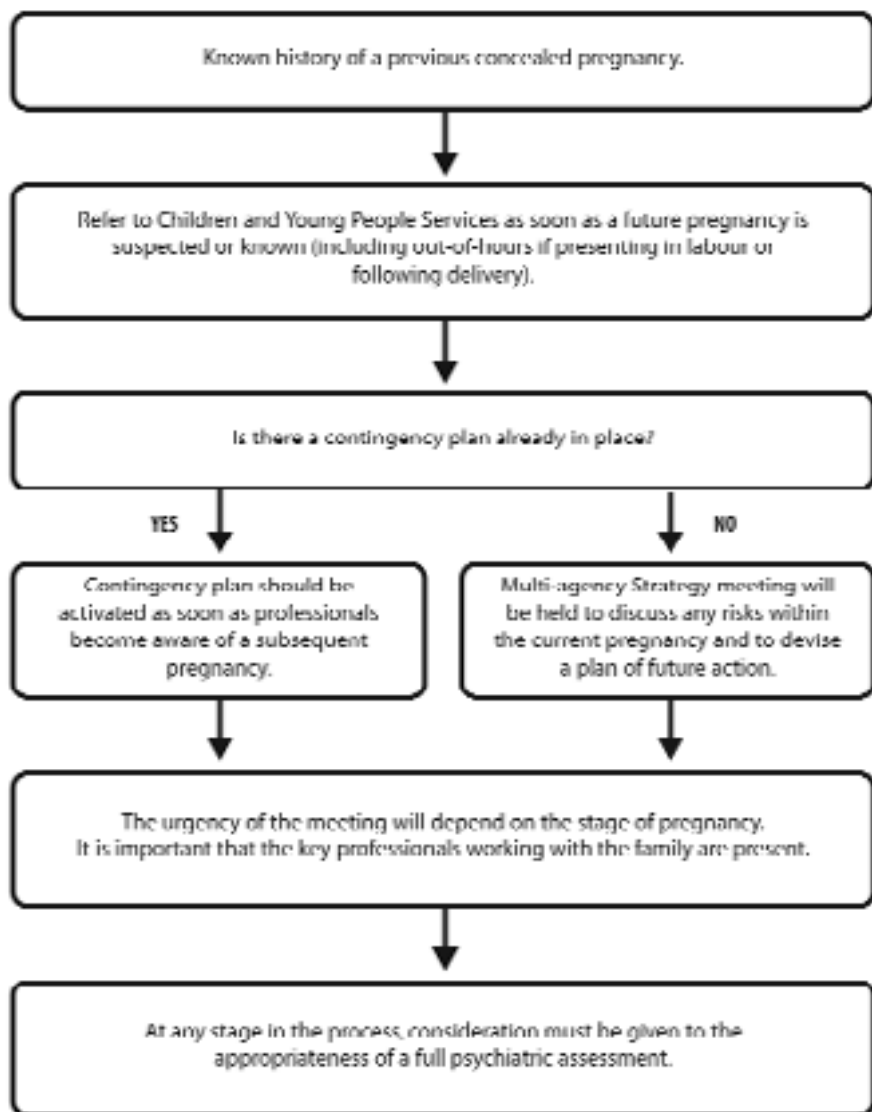
Suspicion arise that a pregnancy may be concealed or denied



Concealment is revealed



Possibility of a future pregnancy when there has been a known concealed or denial of pregnancy



Appendix 3

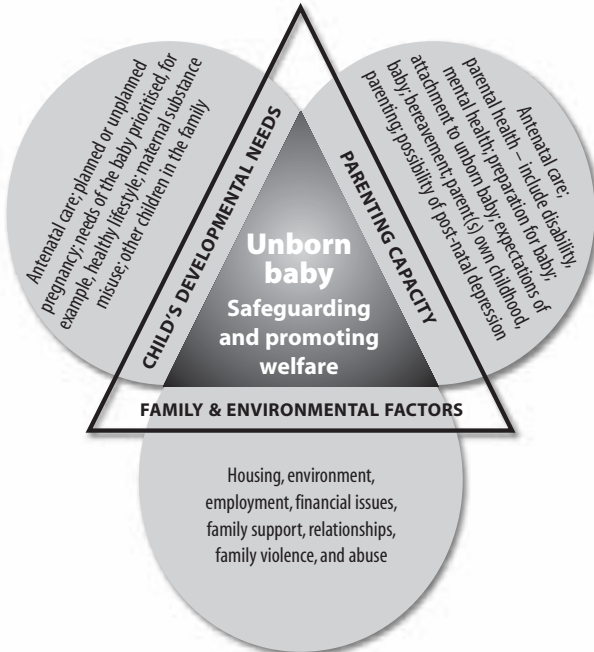
Adapted framework for antenatal assessment

Mother's name:

Partner's name:

EDD:

GPs name:



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

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

Concealed pregnancy risk indicators

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
1 Lack of pre-natal care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Previous concealed pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Irrational perceptions / fears about being pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Lack of suspicion by family/partners/colleagues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Poor parenting experiences as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Effects of early sexual trauma, i.e. victim of sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Interpersonal problems with partners and/or family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Anticipation of separation from forthcoming baby (including inability to cope or baby will be taken away)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Emotional problems? (Please clarify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>			
11 Loss of custody of previous child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Presenting with abdominal disorder or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 History of substance misuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Mental health difficulties including:			
Schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Previous rejection of a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Previous Social Care involvement re: childcare, including child protection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 Moving geographical area / address?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Poor relationships with Health Professionals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 Files lost or untraced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 History of not registering with a GP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 Not attending health and/or developmental checks with existing child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22 Thoughts of termination.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23 Lack of information about the father of current pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

continued over >>

Yes	No	No evidence
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24 Family collusion (mother/ daughter relationships)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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25 Inability to provide appropriately for child's needs?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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26 Inability to perceive child's needs?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Analysis and Plan (continue on a separate sheet if necessary)

Person completing this assessment form

Signature: _____

Date: / /

Copy to: _____



The West Sussex Children's Trust is facilitated by West Sussex County Council

The West Sussex Children's Trust partners agencies are:
West Sussex County Council, the NHS in West Sussex, Police, Probation Service, Learning and Skills Council, District and Borough Councils, and the Voluntary Sector.