

# **PART 16**

## **CONCEALED PREGNANCY AND BIRTH**

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## **Purpose of the Guidance**

1. This guidance is intended for professionals who may encounter women who conceal the fact that they are pregnant. It should be applied in conjunction with relevant parallel guidance including, for instance, that contained elsewhere within these Inter-Agency Safeguarding procedures and in other statutory guidance.
2. The concealment of pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the child and the mother respectively. 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. In some cases, however, pregnancies may be concealed until delivery, when particular attention should be given to safeguarding the child's welfare, and indeed to the well-being of the mother.

## **Definition**

3. There is no universally agreed definition of 'concealed pregnancy'. The following definition has been developed as the result of multi-agency consultation, which has taken place in producing this guidance.
4. "A concealed pregnancy is one where, through fear, ignorance or denial, a woman does not accept or is unaware of the pregnancy and so does not access support from appropriate carers or professionals".

## **Reason for Concealment**

5. There is limited research in this area. The reality is that women may have a variety of reasons for their actions.
6. Concealment of a pregnancy may be revealed late in pregnancy, in labour or following delivery. The birth in some cases may be unassisted whereby there are additional risks to the child's survival.
7. 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.
8. Denial may persist as a result of thinking that the problem will go away if it is ignored.
9. Concealment may otherwise be a deliberate means of dealing with the pregnancy without informing anyone about it, due to stigma or shame.

10. 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.
11. A woman who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant.
12. 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 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.

### **Local Context**

13. There is no definitive statistical information relating to the prevalence of concealed pregnancies in Staffordshire.
14. From discussion with midwives and the experience of hospital social workers, anecdotal evidence puts the figure at about 9/10 per year across the three Staffordshire hospitals (excluding women who are resident in Stoke on Trent).
15. Clearly there will also be a number of Staffordshire residents who otherwise access maternity services at Macclesfield, Wolverhampton, Walsall and Sutton Coldfield hospitals.
16. The majority of babies born of concealed pregnancy are healthy and go home with their mothers. However, there have been a number of more exceptional and tragic outcomes.

In Staffordshire a number of cases have been subject to a review by the former Area Child Protection Committee (ACPC). This takes place in the event of a child death or serious injury in which abuse or neglect is thought to be a factor, in order that lessons can be learned for safeguarding children more effectively.

17. Of the cases reviewed to date, there have been a significant number where concealed pregnancy has been identified as a pre-disposing factor.

### **Indicators of a Concealed Pregnancy**

18. The potential risk to a child through the concealment of a pregnancy is extremely hard to predict.

19. Research undertaken in other authorities has found that concealment appears to be reported equally across all ages. It is not just a teenage phenomenon.
20. Previous concealed pregnancy is also regarded as an important indicator in predicting risk of a future pregnancy being concealed with a harmful outcome for the child.
21. They also identified the following indicators:
- previous termination
  - loss of a previous child (i.e. adoption, removal under Care Proceedings)
  - general fear of being separated from the child
22. There could be a number of reasons why women fear that they will be separated from their child. The experience of hospital social workers and midwives suggests that substance misusing women can avoid seeking help during pregnancy as they fear that this disclosure will inevitably lead to removing their child.
23. In the cases reviewed by the Lincolnshire task group, it was found that there often appeared to be family collusion. In such cases, the mother's own family was aware of the situation, and the pregnant daughter was allowed to develop high levels of privacy in the home.

### **Risks/Protection Issues**

24. The reason for the concealment will be the key factor in determining the risk to the child and that reason will not be known until there has been an assessment.
25. Implications of concealment are wide-ranging in terms of accessing appropriate medical/midwifery care, access to after-care and support and sometimes desperation in maintaining concealment inappropriately.
26. Concealment of a pregnancy can lead to a fatal outcome, regardless of the mother's intention.
27. An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery.

28. 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.
29. The health and development of the baby during pregnancy and labour may not have been monitored.
30. Underlying medical conditions and obstetric problems will not be revealed.
31. 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.
32. 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.
33. 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.
34. 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.

### **Where Suspicion Arises**

35. 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.
36. A sense of conflict may arise between breaching confidentiality and the potential concern for the unborn child. There will be a point at which the child's welfare overrides the mother's right to confidentiality.
37. 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. Referrals to other agencies will need to be considered as a child protection referral for the unborn child and since a criminal offence may have sometimes been committed, depending on the circumstances, therefore wider implications for a girl who is under 16 years of age.

- **Education**

38. In many instances teachers may be the professionals who know a young woman best, and undoubtedly 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 (Child Protection) Teacher in addressing these concerns.

39. Where there is significant evidence that a girl is pregnant despite repeated denial, such as:

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

Teachers 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 the School Nurse/Health Advisor may be appropriate in these circumstances.

40. Teachers may often feel the matter can be resolved through discussion with the parents. This will clearly depend on individual circumstances including relationships with parents.

41. This will need to be a matter of professional judgement. 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 which give rise to concern.

42. If teachers do engage with parents they need to bear in mind the possibility of parents' collusion with concealment.

43. Whatever action is taken, whether informing the parents or referral to 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.

44. It may be beneficial to convene a multi-agency meeting with the Education Welfare Officer and School Nurse/Health Advisor. If this is not possible, a referral should be made to the School Nurse/Health Advisor.

45. If there is a lack of progress in resolving the matter, either due to possible collusion by the parent/s or inaction by another agency,

consideration should be given to making a referral to children's social care.

46. 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's social care.

- **Education Welfare Officer and staff working with excluded pupils**

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

48. When faced with significant evidence (as above) that a girl may be pregnant, yet continues to deny this when asked, a referral to children's social care should be made.

49. It may be appropriate to try to resolve the issue with the parents which again will depend on individual circumstances.

50. As with any referral to children's social care, 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.

- **Health**

- **School Nurse/School Health Advisor**

51. The School Nurse/Health Advisor is well placed to work with school age girls who may be pregnant.

52. Offering a confidential service, a step removed from school and with health expertise, the School Nurse/Health Advisor may well be able to help a girl to accept that she needs support. As an initial step it may be helpful to liaise with the G.P and Health Visitor to consider a way forward.

53. However, when faced with continued denial, the School Nurse/Health Advisor should seek advice from the Trust's Child Protection advisers (inc. Named Professionals) to determine whether a referral to children's social care may be appropriate.

- **GPs**

54. Clearly women who are concealing are unlikely to present at GPs for pregnancy tests. However, they may present for other reasons.

55. Generally, as a matter of good practice, in any female presenting with nausea or weight gain, a possibility of pregnancy should be considered and appropriate examination and investigation performed.
56. 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.
57. Where a GP has significant reason to believe a woman is pregnant, but refuses all attempts to persuade her to undertake further investigations, further action needs to be taken. This should include discussion with the School Nurse/Health Advisor, the Health Visitor or the Midwife, any of whom may be able to pursue the matter further or refer on to children's social care or to a hospital clinic. It may be helpful to discuss the concerns with the Designated (or Named) Doctor or Nurse for Child Protection.
58. 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 GP records.

- **Health Visitors**

59. 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.
60. As an initial step it may be helpful to discuss the matter with the GP and the Midwife to consider a way forward.
61. When faced with significant reason to believe a woman is pregnant, and yet in total denial, Health visitors should discuss their concerns with the Trust's Child Protection advisers, to determine whether a referral to children's social care may be appropriate.

- **Mental Health Professionals – Child & Adolescent and Adults Learning Disability Professionals**

62. 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.
63. Mental illness, emotional problems, personality problems and substance mis-use may all be contributory factors as to why some women conceal.

64. There is also an increased likelihood that women using these services may have had previous children removed.
65. Very occasionally, some learning disabled women may be unaware they are pregnant or else may be extremely fearful that their baby will be removed.
66. Mental Health/Learning Disability professionals may be well placed to resolve the matter, given the therapeutic relationship with the woman. However, in the face of determined denial, a referral should be made to children's social care.
67. Again, all health professionals should inform service users if they plan to refer to children's social care 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 children's social care. In such circumstances the situation should be discussed with children's social care to consider how the service user should best be approached.

- **Children's social care**

68. When a referral is made to children's social care regarding a suspicion of concealment, it may be unlikely that the expectant mother will have consented to the referral. Good practice, however, would require consent to disclose that information, unless in doing so obtaining consent would place the child at increased risks of significant harm. The referral will be made due to potential risk to the unborn child and indeed the expectant mother if she is under 16.
69. The referral should be raised in the name of the young girl if she is under 16. If the expectant mother is over 16, the referral should be raised in the name of the unborn child.
70. Where the potential 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.
71. In the event the young woman refuses to engage in constructive discussion, the parents should be informed and plans made wherever possible to ensure the potential baby's welfare. Potential risks to the unborn child would outweigh the young woman's right to confidentiality, if there was significant evidence that she was pregnant.

72. Where the potential expectant mother is over 16, every effort should be made to resolve the issue.
73. 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 and endeavour to make plans to safeguard the baby's welfare at birth.
74. 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 are available at an early stage.
75. 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. It may be appropriate to convene a pre-birth child protection conference.
76. An unborn child has no legal standing. An expectant mother cannot be forced, by law, 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.

### **When Concealment Is Revealed**

77. 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.
78. 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 properly managed.
- **Midwives**
79. If an appointment is made very late for antenatal care, the reason for this must be explored.
80. If there is a cause for concern a referral should be made to children's social care. The young girl/ woman must be informed that the referral has been made, unless there are significant child protection concerns.
81. 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 children's social care. If the woman arrives at a non Staffordshire Hospital, referral should be made to the area children's social care office in the area in which the woman resides.

82. If the baby arrives at the weekend/bank holiday/out of hours the Emergency Duty Service should be contacted.

83. If the baby had been harmed in any way, or abandoned as a result of the mother's actions, a referral must be made to children's social care and the Police must be informed.

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

- **Children's social care**

85. In relation to referrals where there are concerns about late booking for ante-natal care at Staffordshire Hospitals, a social worker will be responsible for undertaking an Initial Assessment on a "Child in Need" basis unless there is significant information to suggest that the child protection procedures should be invoked.

86. The social worker will respond to referrals where a woman has arrived in labour or has been admitted following an unassisted birth.

87. An Initial Assessment will be conducted and the child protection procedures initiated. Lateral checks will be completed. The potential need for a Child Protection Conference should be considered.

88. Where a baby has been harmed, has died or has been abandoned, the referral will be managed by the child protection procedures being invoked.

89. Where the referral is received out of hours, in relation to a baby born as the result of a concealed pregnancy, the Emergency Duty Service will take steps to prevent the baby being discharged from hospital until an assessment has been undertaken. In normal circumstances this would be through a voluntary agreement, though clearly there could be circumstances in which it would be appropriate to apply for an Emergency Protection Order, or to seek the assistance of the Police in preventing the child from being removed from the hospital.

90. In undertaking an assessment the social worker will need to focus on the reasons why the pregnancy was concealed, as well as all the other aspects of the Assessment Framework, as this will be one of the key factors in determining risk.
91. 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 support.
92. This might include Post Traumatic Stress Disorder, risk of post natal depression, the effect if pregnancy was result of abuse, the impact of denial of pregnancy, impact on parenting ability and emotional distress.
93. A psychiatric assessment might be required in some circumstances, such as complete denial of pregnancy.

- **Police**

94. The Police will be notified of any Child Protection inquiries made by children's social care following a concealed pregnancy.
95. 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.
96. 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 children's social care team.