PAN Merseyside Concealed / Denied Pregnancy Protocol

1.1 The purpose of this policy and procedure is for anyone who may encounter a woman who conceals the fact that she is pregnant, where this is a known previous concealed pregnancy or where a professional has a suspicion that a pregnancy is being concealed or denied.

1.2 The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and wellbeing of the foetus (unborn child) and the mother. There may be a number of reasons why a pregnancy is concealed or denied, for example:

- 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;
- A pregnancy may be concealed in situations of domestic abuse, within a forced marriage or for a forced marriage to avoid shame on a family;
- There is growing intelligence that suggests pregnant women are exploited for sham marriages and benefit fraud, likewise the unregulated nature of the surrogacy industry puts women and children at risk of exploitation and trafficking and may not therefore conceal their pregnancies due to control and coercion;
- Due to stigma, shame or fear through cultural or family pressures, concealment may be a deliberate means of coping with the pregnancy or avoiding brining shame on the family;
- Fear of a child being removed where a woman has had a previous child removed, or asylum seekers and illegal immigrants who may be reluctant to inform the authorities that she is pregnant;
- In some cases the woman may be truly unaware that she is pregnant until very late in the pregnancy, either due to age or learning disability if they do not understand why their body is changing;
- There are links between denial of pregnancy and dissociative states brought about by trauma or loss; or denial stems from an expectant mother misusing drugs or alcohol which can harm the foetus or because of mental illness, such as schizophrenia.

While concealment and denial, by their very nature, limit the scope of professional help better outcomes can be achieved by coordinating an effective inter-agency approach. This approach begins when a concealment or denial of pregnancy is suspected or in some cases when the fact of the pregnancy (or birth) has been established. This will also apply to future pregnancies where it is known or suspected that a previous pregnancy was concealed or denied.

2. Definition

2.1 A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or any health professional; or when she tells another professional but conceals the fact that she is not accessing antenatal care; or when an expectant mother tells another person or persons and they conceal the fact from all health agencies.

2.2 A denied pregnancy is when an expectant mother is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases an expectant mother may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005).

2.3 For the purpose of this protocol any reference to an expectant mother includes females of childbearing capacity (including under 18's). A pregnancy will not be considered to be concealed or denied for the purpose of this protocol until it is confirmed to be at least 24 weeks; (in some organisations late booking may be considered earlier than this and Pan Lancashire pre-birth protocol may be considered at 16 weeks where there are significant safeguarding concerns). However by the very nature of concealment or denial it is not possible for anyone suspecting an expectant mother is concealing or denying a pregnancy to be certain of the stage the pregnancy is at.

3. Evidence from Research and Serious Case Review

3.1 Research into concealment and denial of pregnancy is relatively recent, in the last 40 years, and this work has attempted to understand the characteristics of women who conceal or deny their pregnancy. Research has also been carried out to explore links between concealed pregnancy and infanticide (killing of a child in the first year of life). Local Safeguarding Children Boards have conducted reviews of cases where concealment or denial of pregnancy has been identified as a factor in the death or serious injury of a child. The issue of concealment and denial of pregnancy, and infanticide/filicide (the killing of a child by a parent) can be evidenced throughout human history.

3.2 A summary of thirty-five major child death inquiries (Reder P, 1993) highlighted evidence of considerable ambivalence or rejection of some of those pregnancies and a significant number with little or no antenatal care. A follow-up study (Reder P. D., 1999) 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.

3.3 Several studies (Earl, 2000); (Friedman S. M., 2005); (Vallone, 2003) highlight a well-established link between neonaticide - killing of a child by a parent in the first 24 hours following birth - and concealed pregnancy. A review of 40 Serious Case Reviews (DoH, 2002) identified one death was significant to concealment of pregnancy.

3.4 A number of studies have attempted to identify the frequency of concealment or denial of pregnancy (Nirmal, 2006); (Wessel, 2002).
They suggest concealment might occur in about 1:2500 cases (0.04%). A study by (Friedman S. H., 2007) showed a higher proportion with 0.26% of all pregnancies in their sample (approx. 31,000) to be concealed or denied. The characteristics of those in this study showed that 50% of those concealing the pregnancy and 59% of those denying the pregnancy were aged between 18 and 29 years. Only 40% of those concealing and 23% of those in denial of their pregnancy were under 18 years of age.

3.5 A recent study in France into the rate of neonaticide by looking back at judicial data (court cases and inquests) concluded that the rate was 2.1 per 100,000 births, a much higher rate that the official mortality statistics suggested. All of the pregnancies identified in the study were concealed but none were completely denied by the woman (no awareness of being pregnant). The characteristics of the women in the study were explored and over half of them lived with the child's father, and 13 of the 17 women identified were classed as professionally active with a status identical to that of the general population. The authors concluded that neonaticide appeared as a solution to an unwanted pregnancy that risked a family scandal or loss of a partner or lifestyle. (Tursz and Cook, 2010)

3.6 The majority of religious faiths traditionally expect pregnancy to follow after marriage. Dependent upon the culture and religious observance, a pregnancy outside of marriage may have serious consequences for the women involved. This can create a significant pressure on an expectant mother to seek to conceal a pregnancy or for the psychological conditions to be present where a pregnancy is denied. In some local and national cases collusion between family and partners has occurred to facilitate and encourage concealment of the pregnancy from those outside of the family or wider culture/community. Some pregnant women, or their partners, who abuse drugs and /or alcohol may actively avoid seeking medical help during pregnancy for fear that the consequences of increased attention from statutory agencies can result in the removal of their child.

4. Implications of a Concealed or Denied Pregnancy

4.1 The implications of concealment and denial of pregnancy are wide-ranging. Concealment and denial can lead to a fatal outcome, regardless of the mother's intention.

4.2 Lack of antenatal care can mean that potential risks to mother and child may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given; such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy e.g. some epilepsy medication. **NICE** guidance published in October 2017 makes recommendations about practice in relation to children and young people under 18, including unborn babies.

4.3 Underlying medical conditions and obstetric problems will not be revealed if antenatal care is not sought. An unassisted delivery can be very dangerous for both mother and baby, due to complications that can occur during labour and the delivery. A midwife should be present at birth, whether in hospital or if giving birth at home.

Good practice in antenatal care:

- Midwives and GPs should care for women with an uncomplicated pregnancy, providing continuous care throughout. Obstetricians and specialist teams should be brought in where necessary;
- In the first contact with a health professional, an expectant mother should be given information on folic acid supplements; food hygiene and avoiding food-acquired infections; lifestyle choices such as smoking cessation or drug use; and the risks and benefits of antenatal screening;
- The booking appointment with a midwife ideally should be around 10 weeks. This appointment should help the expectant mother plan the pregnancy, offer some initial tests and take measurements to help determine any specific risks for the pregnancy. The expectant mother should be given advice on nutritional supplements and benefits;
- Give information that is easily understood by all women, including those with additional needs, learning difficulties or where English is not their first language. Ensure the information is clear, consistent and backed up by current evidence;
- Remember to give an expectant mother enough time to make decisions and respect her decisions even if they are contrary to your own views;
- Women should feel able to disclose problems or discuss sensitive issues with you. Be alert to the symptoms and signs of domestic violence and abuse.

Adapted from Antenatal care: Routine care for the healthy pregnant woman, NICE, 2008 (NICE update due June 2020)

4.4 An implication of concealed or denied pregnancy could be a lack of willingness or ability to consider the baby's health needs, or lack of emotional bond with the child following birth. It may indicate that the mother has immature coping styles or is simply unprepared for the challenges of looking after a new baby. In a case of a denied pregnancy, the effects of going into labour and giving birth can be traumatic.

4.5 Where concealment is a result of complex social factors, including alcohol or substance misuse and domestic abuse, as set out in the NICE Guidance (Dec 2017), there can be risks for the child's health and development in utero as well as subsequently. There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community; or because revealing the identity of the child's father may have consequences for the parents and the child.

5. Where Suspicion Arises

5.1 This section outlines actions to be taken when a concealed or denied pregnancy is suspected. If a pregnancy is suspected of being concealed or denied, the expectant mother should be strongly encouraged to go to her GP or direct to midwife to access ante-natal care. If the expectant mother accesses her GP, the GP practice will help her register with midwifery services for ultrasound scanning and advice about pregnancy and birth.

5.2 Professionals must balance the need to conserve confidentiality and the potential concern for the unborn child and the mother's health and wellbeing. Where any professional has concerns about concealment or denial of pregnancy, they should contact any other agencies known to have involvement with the expectant mother so that a fuller assessment of the available information and observations can be made.

5.3 Where there is strong suspicion of a concealed or denied pregnancy, it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the pregnant woman will override her right to confidentiality. A referral should be made to the MASH in which the pregnant woman resides, See PAN Merseyside Pre-Birth Protocol. A referral to Adult Social Care may be required if the mother has care and support needs. If the expectant mother is under 18 years, consideration should be given to potential child sexual exploitation, see the PAN Merseyside Child Exploitation Protocol, and whether she is a Child in Need. Where the mother is less than 16 years a criminal offence may have been committed and this needs to be investigated.

5.4 The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the unborn young person or newborn baby.

The reasons will not be known until there has been a multi-agency assessment. If there is a denial of pregnancy, consideration must be given at the earliest opportunity to a referral to enable the expectant mother to access appropriate mental health services for an assessment. Advice can be sought from the designated or named professional or from Children's Social Care.

Legal considerations about concealment and denial of pregnancy:

- United Kingdom law does not legislate for the rights of unborn children and therefore a foetus is not a legal entity and has no separate rights from its mother. This should not prevent plans for the protection of the unborn child being made and put into place to safeguard the baby from harm both during pregnancy and after the birth;

- In certain instances legal action may be available to protect the health of a pregnant woman, and therefore the unborn child, where there is a concern about the ability to make an informed decision about proposed medical treatment, including obstetric treatment. The Mental Capacity Act 2005 states that person must be assumed to have capacity unless it is proven that she does not. A person is not to be treated as unable to make a decision because they make an unwise decision. It may be that a pregnant woman denying her pregnancy is suffering from a mental illness and this is considered an impairment of mind or brain, as stated in the act, but in most cases of concealed and denied pregnancy this is unlikely to be the case;
- There are no legal means for a local authority to assume Parental Responsibility over an unborn baby. Where the mother is a child and subject to a legal order, this does not confer any rights over her unborn young person or give the local authority any power to override the wishes of a pregnant young person in relation to medical help.

6. When a Concealed or Denied Pregnancy is Revealed

6.1 This section outlines actions to be taken when a concealed or denied pregnancy is revealed. Midwifery services will be the primary agency involved with an expectant mother after the concealment is revealed, late in pregnancy or at the time of birth. However it could be one of many agencies or individuals that an expectant mother discloses to or in whose presence the labour commences. It is vital that all information about the concealment or denial is recorded and shared with relevant agencies to ensure the significance is not lost and risks can be fully assessed and managed.

6.2 When a pregnancy is revealed the key question is 'why has this pregnancy been concealed?' The circumstances in each case need to be explored fully with the woman and appropriate support and guidance given to her. Advice should be sought from the agency's Safeguarding Lead and the local MASH. Where possible a full pre-birth assessment should be undertaken and if necessary an Initial Child Protection Plan (Pre Birth) Conference be convened to manage any concerns for the safety of the unborn child. See the PAN Merseyside Pre Birth Protocol.

6.3 When a pregnancy has been concealed / denied up until the point of birth a referral **must be** made by the midwife to Children's Social Care via the local MASH.

7. Educational Settings Including Early Help Services

7.1 In many instances staff in these settings may be the professionals who know a young person best. There are several signs to look out for that may give rise to suspicion of concealed pregnancy:

- Increased weight or attempts to lose weight;
- Wearing uncharacteristically baggy clothing;
- Concerns expressed by friends;
- Repeated rumours around school or college;
- Uncharacteristically withdrawn or moody behaviour;
- Missing from education, child sex exploitation and missing from home (See PAN Merseyside Child Exploitation and Missing Children Protocols).

7.2 Staff working in educational settings, including Early Help, should try to encourage the pupil to discuss her situation, through normal pastoral support systems, as they would any other sensitive issue. Every effort should be made by the professional suspecting a pregnancy to encourage the young person to obtain medical advice.

However where they still face total denial or non-engagement further action should be taken. It may be appropriate to involve the assistance of the Designated Lead Person for Safeguarding in addressing these concerns.

7.3 Consideration should be given to the balance of need to preserve confidentiality and the potential concern for the unborn child and the mother's health and wellbeing. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained.

7.4 Staff may often feel the matter can be resolved through discussion with the parent of the young person. However this will need to be a matter of professional judgment and will be clearly depend on individual circumstances including relationships with parents. It may be felt that the young person 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, such as domestic or sexual abuse, honour based abuse, forced marriage and FGM. If this is the case then a referral to Children's Social Care should be made without speaking to the parents first - see local area LSCB Professional referral website.

7.5 If education staff engage with parents they need to bear in mind the possibility of the parent's collusion with the concealment. Whatever action is taken, whether informing the parents or involving another agency, the young person should be appropriately informed, unless there is a genuine concern that in so doing she may attempt to harm herself or the unborn baby.

7.6 If there is a lack of progress in resolving the matter in the setting or escalating concerns that a young person may be concealing or denying she is pregnant, there must be a referral to Children's Social Care. Where there are significant concerns regarding the girl's family background or home circumstances, such as a history of missing from home, risk of CSE, abuse or neglect, a referral should be made immediately. As with any referral to Children's Social Care, the parents and young person should be informed, unless in doing so there could be significant concern for her welfare or that of her unborn child.

8. Health Professionals

8.1 The local commissioners of health services are responsible for ensuring all its commissioned providers of health care fulfil their statutory responsibilities for safeguarding children.

8.2 The health professionals whom may be involved include:

- Paediatrician;
- Health Visitors;
- School nurses;
- Sexual Health and GUM services;
- General Practitioners and Practice nurses;
- Midwifes and Obstetricians/Gynaecologists;
- Mental Health Nurses;
- Drug and Alcohol workers;
- Learning Disability workers;
- Psychologists and Psychiatrists;
- Commissioned termination of pregnancy services.

(This is not an exhaustive list)

8.3 If a health professional suspects or identifies a concealed or denied pregnancy and there are significant concerns for the welfare of the unborn baby, (s)he must refer to

Children's Social Care and inform all the health professionals, including the General Practitioner, involved in the care of the woman.

8.4 If there are concerns about a woman's mental health consideration must be given to making or initiating a referral for a mental health assessment at any stage of concern regarding a suspected (or proven) concealed or denied pregnancy.

8.5 Accident and Emergency staff or those in Radiology departments need to routinely ask women of childbearing age whether they might be pregnant. If suspicions are raised that a pregnancy may be being concealed, these staff should follow safeguarding procedures (section 5 – where suspicion arises and section 6 When a concealed or denied pregnancy is revealed.

8.6 Health professionals who provide help and support to promote children's or women'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 or denying a pregnancy.

8.7 GP practices should record the concealed pregnancy on both the mothers and baby's notes as this information could be of relevance in future safeguarding decision making.

9. Midwives and Midwifery Service

9.1 If an appointment for antenatal care is made late (beyond 24 weeks), the reason for this must be explored. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby, a referral to Children's Social Care must be made. The expectant mother should be informed that the referral has been made, the only exception being if there are significant concerns for her safety or that of the unborn child.

9.2 If an expectant mother arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, then an urgent referral must be made to Children Social Care. If this is in an evening, weekend or over a public holiday then the Children Social Care Emergency Duty Team must be informed.

9.3 If the baby has been harmed in any way or there is a suspicion of harm, or the child is abandoned by the mother, then the Police must be informed immediately and a referral made to Children's Social Care.

9.4 Midwives should ensure information regarding the concealed pregnancy is placed on the child's, as well as the mother's, health records. Following an unassisted delivery or a concealed/denied pregnancy, midwives need to be alert to the level of engagement shown by the mother, and her partner/extended family if observed, and of receptiveness to future contact with health professionals. In addition midwives must be observant of the level of attachment behaviour demonstrated in the postnatal period.

9.5 Neither baby nor the mother should be discharged until they have had full assessment of their needs, including identification of risks and a multi-agency discharge planning meeting held. A discharge summary from maternity services to the relevant GP must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks).

10. Children's Social Care

10.1 Children's Social Care / Emergency Duty Team may receive a referral from any source, which suggests a pregnancy is being concealed or denied. Safeguarding

processes must be implemented and consideration of an assessment should be made.

This would ordinarily be done by voluntary agreement with the mother, although where the mother's consent is not freely given, consideration should be given to whether there are grounds for seeking an Emergency Protection Order to ensure the baby remains in hospital until a the discharge plan is agreed. Alternatively the assistance of the Police - via Police Protection - may be sought to prevent the child from being removed from the hospital.

If the baby is born at home the midwife or ambulance service (which ever professional is present), should ensure the baby is admitted to hospital even if the mother herself declines her own admission.

In all cases a multi-agency Strategy Meeting should be convened, involving the GP, midwifery services and other relevant agencies to assess the information and formulate a plan. This should inform either a Social Care Child and Family Assessment, or a S47 Child Protection Investigation.

10.2 Where the expectant mother is under the age of 18, initial approaches should be made confidentially to the young person to discuss concerns regarding the potential concealed or denied pregnancy and unborn child. She should be provided with the opportunity to confirm the pregnancy by undertaking appropriate tests or to make plans for the baby. There may be significant reasons why a young person may be concealing a pregnancy from her family and a professional should consider speaking to her without her parent's knowledge in the first instance.

10.3 Where there are clear reasons for suspecting pregnancy in the face of continuing denial or concealment, the professionals will need to continue to assess the situation with a focus on the needs /welfare of woman. It must not be forgotten that where the mother is under 18, she may also be considered a Child in Need or Child in Need or Protection. Such a situation will require very sensitive handling.

10.4 Regardless of the age of the expectant mother where there are additional concerns (i.e. as well as the suspected concealed or denied pregnancy) where risk factors are present, including ongoing/previous child protection concerns Social Care must undertake an appropriate safeguarding assessment.

10.5 If an expected mother has arrived at hospital either in labour or following an unassisted birth when a pregnancy has been concealed or denied, an Assessment of risks is made and Children Social Care are to undertake an appropriate safeguarding assessment.

10.6 Where a baby has been harmed or has been abandoned a section 47 enquiry must be completed in collaboration with the Police. Where a baby has died the Pan Merseyside SUDI (Sudden or Unexpected Death in Infant) Protocol must be initiated.

10.7 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. These factors, along with the other elements of the Continuum of Need and Assessment Framework for Multi Agency Partners and Assessment Framework will be key in determining risk.

10.8 Accessing psychological services in concealment and denial of pregnancy may be appropriate and consideration should be given to referring an expectant mother for psychological assessment. There could be a number of issues for the woman, which would benefit from psychological intervention. A psychiatric assessment might be required in some circumstances, such as where it is thought she poses a risk to herself or others or in cases where a pregnancy is denied.

10.9 The pathway for psychological or psychiatric assessment, either before or after pregnancy, is the same. A referral should be made using the single point of entry to mental health services and the referral letter copied to the woman's GP. The referral should make clear any issues of concern for the woman's mental health and issues of capacity.

11. Police

11.1 The Police will be notified of any child protection concerns received by MASH where concealment or denial of pregnancy is an issue. A police representative must be invited to attend the multi-agency Strategy Meeting and consider the circumstances and to decide whether a joint Child Protection investigation should be carried out.

11.2 Factors to consider will be the age of the expectant mother who is suspected or known to be pregnant, and the circumstances in which she is living to consider whether she is a victim or potential victim of criminal offences. In all cases where a child has been harmed, been abandoned, died, or expected to die it will be incumbent on the Police and Children's Social Care to work together to investigate the circumstances. In cases of a death this will involve the Pan Merseyside SUDI Protocol will be initiated. Where it is suspected that a criminal offence has occurred, or a neonaticide / infanticide has occurred then the Police will be the primary investigating agency.

12. Other LSCB Member Agencies (including the Voluntary Sector)

12.1 All professionals or volunteers in statutory or voluntary agencies who provide services to women of child bearing age should be aware of the issue of concealed or denied pregnancy and follow this procedure when a suspicion arises.

12.2 All referrals will be made to the Children's Social Care initially as a referral on an unborn child. Where the expectant mother is under 18 years of age she will be considered as a Child in Need and assessed accordingly.

13. Bibliography

This guidance is based on the Bury Concealed and Denied Pregnancy Protocol and PAN Lancashire LSCB Concealed and Denied Pregnancy Protocol.

Brezinkha, C. H. (1994). Denial of Pregnancy: obstetrical aspects. Psychosomatic Obstetrics and Gynaecology, 1-8.
DoH. (2002). Learning from Past Experience - A Review of Serious Case Reviews. London: Department of Health.
Earl, G. B. (2000). Concealed pregnancy and child protection. Childright Volume 171, 19-20.
Friedman, S. H. (2007). Characteristics of Women Who Deny or Conceal Pregnancy. Psychosomatics, 117-122.
Friedman, S. M. (2005). Child murder by mothers: A critical analysis of the current state of knowledge and a research agenda. The American Journal of Psychiatry, 1578-1587.
Moyer, P. (2006). Pregnant Women in Denial rarely receive Psychiatric Evaluation. Medscape Medical News (p. Abstract NR930). APA 159 Annual Meeting (May 25 2006).
Nirmal, D. T. (2006). The incidence and outcome of concealed pregnancies among hospital deliveries: an 11 year population based study in South Glamorgan. Journal of Obstetrics and Gynaecology, 118-121.
Reder, P. (1993). Beyond blame; Child Abuse tragedies revisited. London: Routledge.
Reder, P. D. (1999). Lost Innocents: A follow-up study of fatal child abuse. London: Routledge.

Royal College of Obstetrics and Gynaecology. (2006). Law and Ethics in relation to court authorised obstetric intervention. London: RCOG.
Spielvogel, A. H. (1995). Denial of Pregnancy: a review and case reports. Birth, 220-226.
Spinelli, M. (2005). In S. Friedman, Infanticide.
Tursz, A., & Cook, J. M. (2010, December 6). A population-based survey of neonaticides using judicial data. Retrieved October 3, 2011, from Arch Dis Child Foetal Neonatal Ed
Vallone, D. H. (2003). Preventing the Tragedy of Neonaticide. Holistic Nursing Practice, 223-228.
Wessel, J. B. (2002). Denial of Pregnancy: Population based study. British Medical Journal (International Edition), 458.

14. Additional Reading

- Antenatal Care: Routine care for the healthy pregnant woman, Quick Reference Guide. National Institute for Clinical Excellence, 2008
- Law and Ethics in relation to court-authorised obstetric intervention; Ethics Committee Guideline No.1. Royal College of Obstetricians and Gynaecologists. Sept 2006