Concealed Pregnancy

1. Introduction

1.1 This policy and procedure is for anyone who may encounter a woman who conceals the fact that they are pregnant or where a professional has a suspicion that a pregnancy is being concealed or denied. This policy and procedure should be read in conjunction with NSCB multi-agency procedures for safeguarding children. If a link to a section of the multi-agency procedures is required this will be specified in the body text.

1.2 The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and well-being of the unborn child and the mother. While concealment and denial, by their very nature, limit the scope of professional help, better outcomes can be achieved by co-ordinating 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.

2. Definition

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

2.2 A denied pregnancy is when a woman 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 a woman 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 policy and procedure any reference to woman includes female of child bearing capacity (including under 18’s). A pregnancy will not be considered to be concealed or denied for the purpose of this procedure until it is confirmed to be at least 24 weeks; this is the point of viability. However by the very nature of concealment or denial it is not possible for anyone suspecting a woman is concealing or denying a pregnancy to be certain of the stage the pregnancy is at. When making a referral to Children’s Social Care it is not essential to wait until 24 weeks if there is a known pregnancy and obvious safeguarding concerns and the case is likely to be complex.
Concealed Pregnancy and Birth

Suspicions arise that a pregnancy may be concealed or denied

Professional has concerns that a woman or young person is pregnant and is concealing or denying that she is/may be pregnant

Professional to consider the appropriateness of asking woman/young person if they are pregnant

Woman/young person continues to deny pregnancy. Professional remains concerned that a pregnancy is being denied or concealed?

Yes

Discuss with Named Lead for Safeguarding Children within designated area of practice and immediate line manager, document discussions/actions

Refer to CSC who will hold a Strategy Meeting

No

Encourage them to seek antenatal care via GP and follow up as appropriate, document plan of action

GP to discuss with Community Midwives and Health Visitor

Confirm with GP that this has occurred
Concealed Pregnancy is revealed

Pregnancy is revealed late (after 18 weeks), in labour or following delivery where there has been no antenatal care

After 18 weeks

- Late booking for antenatal care (after 18 weeks)

Community Midwife to undertake booking and explore reasons as to why the booking is late

Outcome of Antenatal Assessment may indicate referral to CSC and/or mental health services. Ensure decision making process is clearly documented and sensitively discussed with the woman

In labour / after delivery

- Pregnancy revealed in labour or following delivery

In all cases refer to CSC immediately

- 0191 2772500 (IRS)
- 0191 2328520

Out of Hours (EDT)

- Inform Named Midwife and/or Lead midwife for Safeguarding Children

Baby **must not be discharged** until a strategy meeting has been held by CSC

A full psychiatric assessment **must** be considered prior to the strategy meeting

If the baby has been harmed or abandoned immediately notify the police
Possibility of a future pregnancy when there has been a known concealed or denial of pregnancy

Known history of previous concealed pregnancy

Refer to CSC as soon as a future pregnancy is suspected or known (including out of hours if presenting in labour or following delivery).

Is there a contingency plan in place?

Yes

Contingency plan should be activated as soon as professionals become aware of a subsequent pregnancy

No

Multi agency strategy meeting will be held to discuss any risks within the current pregnancy and to devise a plan of future action

The urgency of the meeting will depend on the stage of pregnancy. It is important that the key professionals working with the family are present

At any stage in the process, consideration must be given to the appropriateness of a full psychiatric assessment
3. Evidence from research and Serious Case Review

3.2 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 and archaeology.

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 fatalit 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 There are 4 studies that at some of the psychological dimensions of concealed and denied pregnancy (Brezinka, 1994); (Earl, 2000) (Moyer, 2006) (Spielvogel, 1995). In some cases a woman may be unaware that she is pregnant until late in the pregnancy due to a learning disability. Concealment may occur as a result of stigma, shame or fear as felt by the woman because the pregnancy is the result of incest, sexual abuse, rape or as part of a violent relationship. Moyer notes that the majority of women who deny pregnancy do not have a mental health assessment. There are links between denial of pregnancy and dissociative states brought about by trauma or loss; or denial stems from a woman misusing drugs or alcohol which can harm the foetus or because of mental illness, such as schizophrenia.

3.5 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 31000) 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.

3.6 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 woman 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 & Cook, 2010)

3.7 In 2010 there was evidence of 4 concealed pregnancies in Bury, and in the North West region of England concealment and denial of pregnancy has been a significant issue in several Serious Case Reviews.

3.8 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 a woman 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 or 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.

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 GP’s should care for woman 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 a woman 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 woman plan the pregnancy, offer some initial tests and take measurements to help determine any specific risks for the pregnancy. The woman 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 a woman enough time to make decisions and respect her decisions even if they are contrary to your own views.

Woman should feel able to disclose problems or discuss sensitive issues with you. Be alert to the symptoms and signs of domestic violence.

Adapted from Antenatal care: Routine care for the healthy pregnant woman, NICE, 2008

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 alcohol or substance misuse 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 (NB Definition in section 2). If a pregnancy is suspected of being concealed or denied, the woman should be strongly encouraged to go to her GP to access ante-natal care. The GP practice will help a woman 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 well-being. Where any professional has concerns about concealment or denial of pregnancy then they should contact other agencies known to have involvement with the woman so that a fuller assessment of the available information and observations can be made.

5.3 Where there is a strong suspicion there is a concealed or denied pregnancy then 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 unborn child will override the mother’s right to confidentiality. A referral should be made to Children’s Social Care Initial Response Service (IRS) team about the unborn child. If the woman is aged less than 18 years then consideration will be given to whether she is a child in need. If she is less than 16 years then a criminal offence may have been committed and 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 child or newborn baby. The reasons will not be known until there has been a systematic multi-agency assessment. If there is a denial of pregnancy then consideration must be given at the earliest opportunity to a referral which will enable the woman to access appropriate mental health services for an assessment. Advice can be sought from the designated or named professional or from IRS at Newcastle Children’s Services.
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 child being made and put into place to safeguard the baby from harm both during pregnancy and after the birth.

- In the case of F (in utero) 1988 the Court of Appeal was asked to make a foetus a ward of court by a Local Authority concerned for the welfare of the child. The pregnant woman's previous child was in foster care and she was described as having a mental disturbance, nomadic lifestyle and occasional drug use. The Court was entirely opposed to the proposed action, with one judge stating that the purpose was to control the woman's actions to protect the unborn child to the extent that she would be ordered to stop smoking, imbibing alcohol and refraining from all hazardous activity (Royal College of Obstetrics and Gynaecology, 2006).

- 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 unborn baby. Where the mother is a child and subject to a legal order, this does not confer any rights over her unborn child or give the local authority any power to override the wishes of a pregnant young woman 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 a woman 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 a woman 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 denied or concealed”? The circumstances in each case need to be explored fully with the woman and appropriate support and guidance given to her. Where possible a full pre-birth assessment should be undertaken by Children's Social Care and if necessary an initial child protection (pre-birth) case conference convened to manage any concerns for the safety of the unborn child. See NSCB Multi-agency Safeguarding Children Procedures.
6.3 When a pregnancy is concealed or denied to birth then a referral must be made by the midwife to Children’s Social Care and mental health agencies for a full multi-agency (including psychiatric) assessment.

7. Educational settings

7.1 In many instances staff in educational settings may be the professionals who know a young woman 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 including information on social networking sites
- Uncharacteristically withdrawn or moody behaviour

7.2 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. Every effort should be made by the professional suspecting a pregnancy to encourage the young woman 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 Person for Child Protection 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 well-being. 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 Education staff may often feel the matter can be resolved through discussion with the parent of the young woman. However this will need to be a matter of professional judgement and will be clearly depend on individual circumstances including relationships with parents. It may be felt that the young woman 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 this is the case then a referral to Children’s Social Care should be made without speaking to the parent’s first.

7.5 If education staff do engage with parents they need to bear in mind the possibility of parent’s collusion with concealment. Whatever action is taken, whether informing the parents or involving another agency, the young woman 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 woman may be concealing or denying she is pregnant there must be a referral to IRS at Children’s Social Care. 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 immediately. As with any referral to Children’s Social Care, the parents and young woman 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 Clinical Commissioning Groups (CCG’s) will be (from April 2013) responsible for commissioning of maternity services in hospital and community settings. The local commissioners of health services are responsible for ensuring all its providers fulfil their statutory responsibilities for safeguarding children.

8.2 The health professionals involved include:

- Health Visitors
- School Health Advisors
- General Practitioners and Practice nurses
- Midwives and Obstetricians/Gynaecologists
- Mental Health Nurses
- Drug and Alcohol workers
- Learning Disability workers
- Psychologists and Psychiatrists

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 they must refer to Children’s Social Care and to inform all the health professionals, including the General Practitioner, involved in the care of the woman.

8.4 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 suspected (or proven) concealed or denied pregnancy. Emergency staff or those in Radiology departments 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 for follow up with the patient.

8.5 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.

9. Midwives & Midwifery Services

9.1 If an appointment is for antenatal care is made late (beyond 24 weeks) the reason for this must be explored. Midwives and Obstetricians should consider whether a mental health referral is indicated. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby then a referral to Children’s Social Care must be made. The woman 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 a woman 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 the Children’s Social Care. If this occurs on an evening, weekend or over a public holiday then the 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 early postpartum period.

9.5 In cases where there has been concealment and denial of pregnancy, especially where there has been unassisted delivery, a referral for a full mental health assessment should be considered. In addition the baby should not be discharged until a multi-agency strategy meeting has been held and relevant assessments undertaken. A discharge summary from maternity services to primary care 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 may receive a referral from any source which suggests a pregnancy is being concealed or denied. In all cases a multi-agency strategy meeting will be convened, involving the General Practitioner, midwifery services and other relevant agency to assess the information and formulate a plan. A pre-birth assessment will be undertaken.

10.2 Where the expectant mother is under the age of 18 initial approaches should be made confidentially to the young woman to discuss concerns regarding the potential concealed pregnancy and unborn child. She should be provided with the opportunity to satisfy social workers that she is not pregnant, by undertaking appropriate medical examination or investigation, or to make realistic plans for the baby, including informing her parents.

10.3 In the event that the young woman refuses to engage in constructive discussion, and where parental involvement is considered appropriate to address risk, the parent/main carer should be informed and plans made wherever possible to ensure the unborn 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. There may be significant reasons why a young woman may be concealing a pregnancy from her family and a social worker may need to consider speaking to her without her parent’s knowledge in the first instance.

10.4 If the young woman refuses to engage in constructive discussion then the social worker will need to inform her parent/s or carers and continue to assess the situation with a focus on the needs/welfare of the unborn baby as well as those of the young woman, who should be considered a child in need. In this situation professionals will have very clear reasons for suspecting pregnancy in the face of continuing denial or concealment and such a situation will require very sensitive handling.
10.5 Regardless of the age of the woman where there are additional concerns (to the suspected concealed or denied pregnancy) such as a lack of engagement, possibility of sexual abuse, or substance misuse; then a Section 47 child protection enquiry will be undertaken. The only outcome will be to convene a pre-birth child protection conference. Where a woman under age 18 is suspected of being pregnant then professionals must not lose sight of the fact that she is also a child in need.

10.6 If a woman has arrived at hospital either in labour (when a pregnancy has been concealed or denied) or following an unassisted birth an initial assessment must be started and a multi-agency strategy meeting convened. In all cases the need to convene a Child Protection Conference must be considered.

10.7 Where a baby has been harmed, has died or has been abandoned then a Section 47 investigation must be completed in collaboration with the Police.

10.8 Any referral received by children’s social care’s Emergency Duty Team in relation to a baby born following a concealed or denied pregnancy, or where a mother and baby have attended hospital following an unassisted delivery, steps must be taken to prevent the baby being discharged from hospital until a multi-agency strategy meeting has been held and a plan for discharge agreed. This would ordinarily be done by voluntary agreement with the woman, although clearly circumstances may arise when it may be appropriate to seek an Emergency Protection Order. Alternatively the assistance of the Police may be sought to prevent the child from being removed from the hospital.

10.9 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 Assessment Framework will be key in determining risk.

10.10 Accessing psychological services in concealment and denial of pregnancy may be appropriate and consideration should be given to referring a woman 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.

10.11 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 PVP Unit will be notified of any child protection concerns received by children’s social care where concealment or denial of pregnancy is an issue. A police representative will be invited to attend a 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 woman whom 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 or died it will be incumbent on police and social care to work together to investigate the circumstances. Where it is suspected that neonaticide or infanticide has occurred then the Police will be the primary investigating agency.

12. Other NSCB 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


14. Additional Reading

2. Law and Ethics in relation to court-authorised obstetric intervention; Ethics Committee Guideline No.1. Royal College of Obstetricians and Gynaecologists. Sept 2006

15. Acknowledgements

This document is based on a policy published by Bury Safeguarding Children Board 2012 following a Serious Case Review.

Contact numbers

To be linked to contact list
1. Initial Response Service 0191 2772500
2. Out of Hours 0191 2328520