**13.0 Concealed Pregnancy Guidance**

**13.0.1** The concealment or denial of a pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the unborn baby and the parent. Research demonstrates that better outcomes can be achieved by co‐coordinating an effective multi‐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 labour or following delivery, when particular attention should be given to safeguarding the welfare of the baby and to the well-being of the person giving birth.

**13.0.2** A late booking may indicate safeguarding concerns or no concerns at all. This guidance deals with cases where the pregnancy has been identified or suspected to be deliberately concealed.

**13.1 Aim**

**13.1.1** The aim of this guidance is to provide frontline professionals with a knowledge base and action strategy for the assessment, management and referral of persons of child baring age who are concealing the fact that they are pregnant or where there is a known previous history of concealed or denied pregnancy.

**13.2 Definition**

**13.2.1** This guidance applies to any person of child bearing age.

**13.2.2** A concealed pregnancy is when a person knows they are pregnant but does not tell anyone; or a person advises someone about the pregnancy but conceals the fact they are not accessing antenatal care or where a person appears genuinely unaware they are pregnant. A denied pregnancy is when a person is unaware of or unable to accept the existence of their pregnancy.

**13.2.3** Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought.

**13.2.4** This can become apparent at any stage of the pregnancy. Concealment of pregnancy may be revealed late in pregnancy; in labour; or following delivery. The birth may be unassisted and may carry additional risks to the baby and person's welfare.

**13.2.5** A late booking is defined as presenting for maternity services after 20 weeks of pregnancy. A booking appointment with a midwife should be around 10 weeks ([NICE 2008](https://www.nice.org.uk/guidance/cg62)). In all cases a person who presents to antenatal care late in their pregnancy should continue to be assessed for any risk factors and any reasons for the delay in presentation should form part of the assessment, regardless of whether there is ongoing engagement with services.

**13.2.6** The pregnancy may be undetected where both the person and health care providers are unaware that the person is pregnant (e.g. a peri-menopausal person with an abdominal lump initially suspected to be a tumour). Conscious concealment of pregnancy is where a person is aware of their pregnancy and is emotionally bonded to the unborn baby but does not tell anyone. The pregnancy may also be denied; this may be conscious denial where the person has physical awareness of their pregnancy, but lacks emotional attachment to the foetus, or unconscious denial where the person is not subjectively aware of their pregnancy and genuinely does not believe the signs of pregnancy or even the birth of the baby (e.g. Psychotic delusion).

**13.2.7 Migrant pregnant person**: professionals should consider the set of circumstances for a person who has presented late in pregnancy and been without access to health care; an interpreter should always be used in such circumstances where a person's language skills would prevent a risk assessment on booking into antenatal care.

**13.2.8 Unassisted or free birth** is when a person gives birth without medical or professional help. It is a criminal offence for anyone other than a registered midwife or doctor to attend a person during childbirth except in an emergency. ([Article 45 of the Nursing and Midwifery Order](http://www.legislation.gov.uk/uksi/2002/253/pdfs/uksi_20020253_en.pdf)). Free birth is a conscious choice and in itself does not require multi-agency involvement. ; however if safeguarding concerns are identified a referral to CSC should be made.

**13.3 Risks/Safeguarding Issues**.

**13.3.1** The reason for any concealment will be a key factor in determining the risk to the unborn/child, the person who has given birth and any other children in the household; in all cases, a holistic risk assessment should be undertaken to ascertain the reason for the concealment.

**13.3.2** Where there is concealment, there may be risks for the baby's health and development in utero, especially where alcohol or substance misuse is a factor in the concealment. There may also be risks to the unborn baby from any prescribed medications.

**13.3.3** A pregnancy may be deliberately concealed in situations where there is domestic abuse; evidence is clear that domestic abuse is more likely to begin or escalate during pregnancy. It may be due to previous involvement with children’s social care, which resulted in the removal of previous child/children. Concealment may also be a result of a person being exploited, subject to trafficking or has suffered FGM.

**13.3.4** There may be risks to both person and baby if the person has concealed the pregnancy due to fear of disclosing the paternity of the baby, for example, where the baby has been conceived as the result of sexual abuse. Adolescents may conceal their pregnancy due to fear of recrimination from their parents or peers or professionals.

**13.3.5** Late booking can be the result of a person presenting for a termination of pregnancy but unable to have this procedure as the pregnancy is over 24 weeks. Professionals need to consider the reasons for presenting late to termination services, associated risk factors, and level of support needed when the person continues with an unwanted pregnancy including their psychological support needs. Consideration should be given to a completing a Multiagency Safeguarding Hub (MASH) referral,

**13.3.6 Implications**

**13.3.7** The implications of concealment are wide-ranging. Concealment of a pregnancy can lead to a fatal outcome, regardless of the person’s intention. Concealment may indicate ambivalence towards the pregnancy, immature coping styles, a tendency to dissociate, or serious mental illness (e.g. psychosis) all of which are likely to have a significant impact on bonding and parenting capacity.

**13.4 Recognition and Referral: Action on suspecting concealed pregnancy.**

**13.4.1 Young People aged under 18** - Whilst it is recognised, at 16 and 17yrs a person is more likely to have the mental capacity to make informed decisions, they are still legally a child.

**13.4.2** If a young person under 18 years is thought to be pregnant and denying or concealing the pregnancy, the professional who has the suspicion should ask the young person if they are pregnant.

**13.4.3** The young person should be supported in seeking the attention of a medical professional in order to receive appropriate healthcare and investigations; if pregnancy is confirmed a there should be a sensitive, confidential discussion regarding choices, ideally guided by what the young person sees as their need. Engaging with the young person at this stage allows the opportunity to explore any safeguarding concerns and what support can be offered by external agencies.

**13.4.4** If the young person declines to engage in supportive discussion, and it is suspected they are pregnant, the professional/s involved must refer to children’s social care for a pre-birth multi-agency assessment according to HIPS procedures. Please refer to UBB Pathways for ongoing care planning. Please note that in these circumstances, potential safeguarding concerns outweigh the young person’s right to confidentiality. We have to advise the young person that we have a duty to share this information with CSC and as a result their parents are likely to be informed. Local teenage pregnancy guidance and pathways should be followed. Social care colleagues should consider, in conjunction and with consent from the young person, notifying the young person’s education setting if appropriate.

**People aged 18 years and over:**

**13.4.5** Every effort should be made to confirm whether they are pregnant or not. Although no one can be forced to undergo a pregnancy test, or any other medical examination, in the event of refusal, professionals should proceed on the assumption that the person is pregnant, until or unless it is proved otherwise, and endeavour to make plans to safeguard the baby at birth. A referral should be made to MASH and liaison with other professionals will need to take place.

**Pregnant person with a learning disability**

**13.4.6** Should there be a concern that the person has a learning disability the person can be referred to the Learning Disability Team via the GP. This would only be with consent from the pregnant person and should not be considered as a routine referral, it has to be the individual’s choice. Additional support from health professionals, including community nursing and psychology can be provided that may help with enhancing the person’s understanding of pregnancy and birth and provide emotional and psychological support before and after the birth of the baby.

**Pregnant person with additional mental health needs**

**13.4.7** Should there be concerns about a person’s mental health, the person should be offered a referral to mental health services. This may include perinatal mental health services and may include an assessment of attachment and bonding to their new-born baby. This can be invoked during the antenatal period if discovered in time.

**13.4.8** It is unusual for a woman to refuse offers of extra support in these cases; therefore, in any event, if a mental health or perinatal mental health assessment is judged necessary by a clinician and the woman declines to access it, this should increase the clinicians’ concerns about the baby’s wellbeing and strengthen the need to consider a referral to MASH.

**13.5 Planning and Intervention**

**Children’s Social Care**

**13.5.1** An unborn baby has no legal standing in the UK. Law cannot force an expectant person to have any medical intervention at birth unless they lack capacity, which has been assessed in line with the Mental Capacity Act, and if there is an unassisted delivery; the lack of professional involvement may lead to undiagnosed complications which could have serious outcomes for mother and/or baby where medical intervention is judged to be necessary and in the person’s best interest. It is only possible to make appropriate contingency plans and to ensure that the individual is fully aware of the consequences of their actions. In all cases, legal advice should be sought.

**13.5.2** Where a person is in the third trimester (more than 27 weeks pregnant) and there are concerns about late presentation or lack of engagement, a referral to MASH needs to be considered.

**13.5.3** In the situations where a person presents during labour then a referral to MASH must be made.

**13.5.4** If a person presents following unassisted delivery at the end of a concealed pregnancy then a referral to MASH must be made.

**Health Professionals**

**13.5.5** A wide variety of health professionals may be in contact with people of child bearing age and should consider, where circumstances suggest it, whether a pregnancy is being concealed. This includes those professionals working directly with people who are inpatients, and those in community or primary care settings.

**13.5.6** Those professionals working in mental health and learning disability may also be involved with a person who is concealing a pregnancy.

**13.5.7** Mental illness, emotional problems, personality problems, a learning disability or substance misuse may all be contributory factors as to why some people conceal the fact that they are pregnant.

**13.5.8** The health professional identifying the potential concealment of a pregnancy should inform the person of plans to refer to the MASH, *unless to do so would place the unborn baby or the person at significant risk* of harm, such as domestic abuse and share the information with health colleagues including midwifery, GP and 0-19 Services to ensure access to appropriate services and support.

**13.5.9** Clear contemporaneous documentation of conversations and actions should be added to the person’s record.

**13.5.10** Given that a previous concealed pregnancy indicates increased risk of further concealment, where this has been the case it should be highlighted in the G.P., midwifery, mental health and health visiting records.

**13.5.11** As partner agencies of the LSCPs, health professionals will be expected to participate in, and contribute to, multi‐agency assessment of risk and to the provision of additional support to the baby and family as appropriate.

**13.5.12** At any stage, professionals should consider involving local specialist services who are experts in working with young people; for example sexual health outreach services or the Family Nurse Partnership.

**Staff in Educational Settings**

**13.5.13** If a member of school staff is concerned that a pupil is attempting to conceal or deny a pregnancy or appears to be unaware that they may be pregnant, the following procedures should be followed:

* Inform the Designated Safeguarding Lead (DSL) or Head Teacher
* Discuss concerns with the pupil, unless in doing so you consider this may increase the risk of harm to the student or to their unborn baby.
* Seek consent from the pupil to share your concerns with their parents or carers. If the pupil is reluctant to consent to their parents or carers being informed this must be treated with sensitivity and respect but the pupil must be informed that a referral will be made to MASH.
* Inform the pupil and their parents of your intention to share your concerns with MASH in the area in which the pupil resides.
* Document conversations with the pupil and their parents or carers contemporaneously and a copy of the written referral to MASH, retained in the child’s confidential school record.

**13.5.14** As partner agencies of the LSCPs school staff will be expected to participate in, and contribute to, a multi-agency assessment of risk to the child and their unborn baby and to the provision of additional support to the child and family as appropriate.

**Police**

**13.5.15** The Police will be notified of any referral that may require s47 enquiries to be made by Children’s Services Social Care following a concealed pregnancy.

**13.5.16** Strategy discussions will determine further police involvement.

**Other Agencies**

**13.5.17** All professionals from statutory and voluntary agencies who provide services to people of child bearing age, should be aware of the risk indicators of concealed or denial of pregnancy and how to act on these concerns; for example, contact children’s social care, follow local child protection procedures.

**13.6 Following delivery of a concealed pregnancy: Immediate Protective Actions, following LSCP child protection procedures.**

**13.6.1** In some cases, depending on identified risks, babies may need to be placed somewhere else other than with their parents and generally this would be a voluntary agreement*;* although clearly there could be circumstances in which it might be necessary 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.

**13.6.2** In both situations Children's Social Care should consider allocating the assessment to a worker with mental health (MH) expertise or seek advice from a MH professional when undertaking an assessment.

**13.6.3** If the baby has been harmed, has died or been abandoned, child protection procedures should be followed.

**13.6.4** The discharge summary from maternity services to primary care and health visiting services must record if a pregnancy was concealed or booked late (after 20 weeks). Midwives, 0-19 Service, mental health professionals (where applicable) and GPs should ensure that information regarding the concealed pregnancy is placed on the baby's records, as well as the person's records.

**13.6.5** The health visitor must be informed prior to the person being discharged from hospital, to enable the required level of antenatal and postnatal targeted support to be put in place.

**13.6.6** Following a concealed pregnancy or unassisted delivery, midwives, health visitors and GPs need to be alert to:

* An enhanced level of professional engagement required for the pregnant person to include a Family Approach
* Difficulties with bonding, attachment and post-natal mental health issues as well as infant mental health
* The receptiveness to future engagement with health professionals
* An awareness of and vigilance for, disguised compliance
* An increase in risk of domestic abuse and sexual violence.

**13.7 Future Pregnancies**

**13.7.1** Following a concealed pregnancy where significant risk has been identified, Children's Social Care 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 Children's Social Care if a future pregnancy is suspected.

**13.7.2** Where it is known there is a history of previous concealed pregnancy, referral must be made to the MASH as soon as any subsequent pregnancy is known. People who have already concealed a pregnancy are at a particular risk of doing so in the future.

**13.7.3** Children's Social Care 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 baby and professionals will need to accept this may be without the consent of the person concerned.

**13.7.4** Only when the underlying reasons for a previous concealed pregnancy are revealed, explored and addressed, can the risk associated with future concealment be substantially reduced.

**13.7.5** Where there is a known plan in place, it should be activated as soon as professionals become aware of a subsequent pregnancy. The urgency of the meeting will depend on the stage of pregnancy. It is important that all key professionals working with the family are included. At any stage in the process, consideration must be given to the appropriateness of a full psychiatric assessment.