

NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD
CONCEALED PREGNANCY

Please note that providers of health services, in particular those providing midwifery services, may have their own detailed agency specific guidance which should be read in conjunction with this guidance. All agencies should follow the Interagency Concealed Pregnancy Guidelines.

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1. PURPOSE AND DEFINITION

This guidance is intended for professionals who may encounter women who conceal the fact that they are pregnant or where there is a known previous concealed pregnancy. The guidance should be applied in conjunction with the LSCB Procedures with particular reference to the Information Sharing Procedure, and the Referrals Procedure

There is no national agreed definition of what constitutes a concealed pregnancy but a study carried out by The Crisis Pregnancy Agency (CPA) revealed that the main reasons for concealing or denying a pregnancy are fear of the social stigma of becoming pregnant in unconventional circumstances and fear of the family's reaction.

The concealment of pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the foetus (unborn child) and the mother. While concealment by its nature limits the scope of professional help, experience shows that better outcomes can be achieved by co-ordinating an effective inter-agency approach once the fact of the pregnancy is established. This will also apply to future pregnancies where there has been a previous concealed pregnancy. In some cases, pregnancies may be concealed until or after delivery, when particular attention should be given to safeguarding the child's welfare, and indeed to the wellbeing of the mother.

A Review of forty Serious Case Reviews (DH 2002) identified one death was significant to concealment of pregnancy. Earl (2000, Friedman et al (2005), Vallone & Hoffman, highlight that there is a well-established link between neonaticide – infanticide in the 24 hours following birth – and concealed pregnancy.

2. INDICATORS

Where Previous concealed pregnancy may be regarded as an important indicator in predicting risk of a future pregnancy being concealed.

Research also identified the following indicators:

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

There could be a number of reasons why women fear that they will be separated from their child:

- Research evidence suggests that substance-misusing women may avoid seeking help during pregnancy if they fear that this disclosure will inevitably lead to statutory agencies removing their child. It may be important to consider the role of collusion within the family. In some national and local cases, the family appeared to encourage the concealment and the mother's own family were aware of the situation, and the pregnant daughter was allowed to develop high levels of privacy in the home;
- 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;
- A woman or girl may conceal their pregnancy if it occurred as the result of sexual abuse, either within or outside the family, due to her fear of the consequences of disclosing that abuse.

3. CONCERNS IN RELATION TO THE AGE OF THE MOTHER

Where the mother is, or may have been at the time of conception, under the age of 16, professionals should follow the processes outlined in the [Underage Sexual Activity](#).

4. IMPLICATIONS: RISK AND PROTECTION ISSUES

The potential risk to a child through the concealment of a pregnancy is extremely hard to predict. One key implication is that there is no obstetric history or record of antenatal care prior to the birth of the baby. Some women may present late for booking (after 24 weeks of pregnancy) and these pregnancies need to be closely monitored to assess future engagement with health professionals, particularly midwives and whether or not referral to another agency is indicated. Research undertaken in other authorities has found that concealment appears to be reported equally across all ages. It is not just a teenage phenomenon. Nirmal, Thijs, Bethel & Bhal (2006) identified a preponderance of concealed pregnancies during the winter months.

The reason for the concealment will be a key factor in determining the risk to the child and that reason will not be known until there has been a systematic multi-agency assessment.

The implications of concealment are wide-ranging:

- Concealment of a pregnancy can lead to a fatal outcome, regardless of the mother's intention;
- The Saving Lives, Improving Mothers Care (2015) report shows 9% of maternal deaths as a result of psychiatric causes had received no antenatal care;
- 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;
- 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;

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- The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected;
- Underlying medical conditions and obstetric problems will not be revealed;
- An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery;
- Lack of maternal willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth. Nirmal et al (2006) identify denial of pregnancy as a likely precursor of poor adaptation postpartum and highlights the need for increased monitoring in the postpartum period;
- 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;
- Risks to the unborn baby from medications prescribed for the mother, which would be contraindicated in pregnancy;
- Late presentation due to concealed pregnancy will lead to a difficulty in assessing gestational age for obstetric planning.

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.

ADDITIONAL RISK FACTORS

In the following circumstances of a pregnancy, a FFAP referral may be appropriate in order that a multi-agency assessment of risk can be determined:

- Children under the age of 13 (a FFAP referral is required in all circumstances where the child is under 13);
- Children between the ages of 13 and 16 years;
- Risk factors associated with sexual exploitation;
- Abuse of drugs/Alcohol by the pregnant woman (or Partner);
- Mother not thought to be able to care for the child;
- Unable to provide for herself or her Baby;
- Subject of Domestic Abuse;
- Mother has had previous children removed from her care or subject to child protection (A FFAP referral is required in all such circumstances;)
- Mother has Learning Disabilities/Physical Disabilities/Mental Health Difficulties where she is unable to care/provide for the child and has little or no support.

5. PROTECTION AND ACTIONS – WHERE SUSPICION ARISES

Where a professional has suspicions that a pregnancy may be concealed they should follow the process as per the flowchart in [Click here to view Appendix C: Suspicions Arise that a Pregnancy may be Concealed or Denied](#).

There is a need to balance the need to preserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. There will be a point at which the child's welfare overrides the mother's right to confidentiality. This is a relevant consideration even though the baby is in utero.

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 See section on Information Sharing. Every effort should be made by the person alerted to suspicion of concealed pregnancy to encourage the (young) woman to obtain medical advice. If the response shows that this is unlikely referral should be made to FFAP so that effective service responses may be coordinated.

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Where anyone has such concerns, they should endeavour to establish whether there is already an open assessment or previous referral to FFAP and/or contact other agencies known to have involvement with the young/woman so that a fuller assessment of the available information and observations can be made.

If concerns are such that a Child Protection referral (see the Referrals Procedure), needs to be made to FFAP, the referral will be made on the unborn child. If the mother is under 16, she will also be the subject of a referral as there may also be a criminal offence to be investigated.

If Consent is obtained then a referral may be appropriate.

6. WHEN CONCEALMENT IS REVEALED

UK law does not legislate for the rights of the unborn baby. In some circumstances, agencies or individuals are able to anticipate the likelihood of Significant Harm with regard to an expected baby.

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

Where a concealed pregnancy is identified, the key question is **'why has the pregnancy been denied/concealed?'** Referring to research and the commentary above, some effort should be made to identify likely reasons for the concealment. **The circumstances leading to concealment of pregnancy need to be explored individually as there may be potentially serious child protection outcomes as a result of a concealed pregnancy and a detailed interagency assessment should be undertaken.** (See **Appendix D: Concealment is Revealed**). If the expectant mother is under 18 years, consideration will be given to whether she is a Child in Need. In addition, if she is less than 16 years then a criminal offence may have been committed and this needs to be investigated.

Where the girl/woman does not speak English as a first language an interpreter must always be sought. It is not appropriate to use family members to translate as this could put the girl/woman at risk of harm.

While midwifery services will be the primary agency involved with the woman after the concealment is revealed, other agencies/ services could be the first to identify a concealed pregnancy, or receive a disclosure.

All agencies should ensure that information about:

- **The pregnancy is shared directly with midwifery services; and**
- **The concealment is shared with other relevant agencies, via the Single Assessment to ensure its significance is not lost and to ensure that potential future risks can be fully assessed and managed.**

A referral to FFAP must always be considered where there are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care, non-co-operation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby. This may ultimately be effectively managed through the Single Assessment process.

If it is known that concealment of pregnancy is under duress or there is known domestic abuse, a risk assessment should determine whether this meets the threshold for a referral to Multi Agency Risk Assessment Conference (MARAC).

In cases of full concealment followed by unassisted delivery, FFAP must always be informed and a full psychiatric assessment considered jointly by the agencies. Assessment should include the possible contribution of the painful reactivation of childhood trauma (Spielvogel et al 1995).

Assessments should identify clear expectations of parents and should they fail to comply this would constitute a significant risk factor and point to the need to activate child protection processes and/or care proceedings. (see **Appendix D: Concealment is Revealed**).

6. AGENCY ACTIONS

All professionals should follow the process as highlighted above in Protection and Actions section above. However, professionals should also follow the section below as relevant to their role.

STAFF IN EDUCATIONAL SETTINGS

In many instances staff in educational settings may be the professionals who know a young woman best. Supportive, caring and non-judgmental pastoral support systems within schools can be extremely valuable in resolving problems at an early stage. It may be appropriate to engage the assistance of the school's Child Protection Coordinator in addressing these concerns.

Staff in educational settings may become concerned that a girl is pregnant despite repeated denial, as a result of:

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

In these circumstances, staff should try to encourage the pupil to discuss her situation, through normal pastoral support systems, as they would any other sensitive problem. However, where they still face total denial further action should be considered. Negotiating the early assistance of, or referral to, the School Nurse may be appropriate in these circumstances.

Education staff may feel the matter can be resolved through discussion with the parent of the young woman/girl or other agencies already involved. However, this will need to be a matter of professional judgement and will clearly depend on individual circumstances including relationships with parents. It may be felt that the girl will not admit to her pregnancy because she has genuine fear about her parents' reaction, or there may be other aspects about the home circumstances that give rise to concern. If education staff do engage with parents they need to bear in mind the possibility of parent's collusion with concealment. Whatever action is taken, whether informing the parents or involving another agency, the girl should be appropriately informed, unless there is a genuine concern that in so doing, the girl may attempt to harm herself or her unborn baby.

It will be beneficial to convene a multi-agency meeting to include the Education Welfare Service, School Nurse and other appropriate professionals.

If there is a lack of progress in resolving the matter, either due to possible collusion by the parent, or inaction by another agency, there should be a referral to FFAP.

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 FFAP.

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

HEALTH

Where possible, Health professionals should inform the service users, if there are significant concerns for the child's welfare, and they plan to refer to FFAP. 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 FFAP. In such circumstances the situation should be discussed with the Named Nurse or Midwife for the relevant health service, and FFAP to consider how the service user should best be approached.

MIDWIVES AND MIDWIFERY SERVICES

Women concealing their pregnancy are unlikely to present for pregnancy tests. However, if a referral is made by the GP or other health professional, the midwife in particular has a unique opportunity to observe attitudes towards the foetus and identify potential problems during pregnancy, birth and the child's care.

If an appointment is made very late for antenatal care (after 24 weeks of pregnancy), the reason for this must be explored. Midwives and Obstetricians should always consider whether there is a need for a referral to other agencies such as Mental Health Services and ensure the use of routine enquiry into domestic abuse.

If there is a cause for concern, advice can be sought from the Named Midwife for Northern Lincolnshire and Goole NHS Foundation Trust, and a referral should be made to FFAP. The young girl / woman must be informed that the referral has been made, unless there are significant reasons not to do so, e.g. she may abscond.

If a young girl/woman arrives at the hospital in labour or following an unassisted delivery, and has not been booked with maternity services locally (or in their own locality if they do not reside in this area), a referral should always be made to Children's Social Care in the area where the woman resides.

If the baby arrives at the weekend/bank holiday/out of hours the contact should be made to the out of hours service for Children's Social Care.

If the baby had been harmed in any way, or abandoned as a result of the mother's actions (or non-action), a referral must be made to FFAP and the Police must be informed immediately.

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

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

Midwives must be alert to the level of attachment/behaviour between mother and child demonstrated in the early postpartum period.

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

In the cases of full concealment, the baby should not be discharged from hospital until a multi-agency / strategy meeting has been held and relevant assessments undertaken.

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

SCHOOL NURSING

The School Nurse may be well placed to identify and work with school age girls who may be pregnant. Their ability to offer a confidential service, within, but not employed by, the young person's school and with health expertise, the School Nurse may be able to help a girl to accept that she needs support. The School Nurse should liaise closely with the Consultant Midwife for Teenage Pregnancy in order to support the young person having gained consent from the young person. However, when faced with continued denial, the School Nurse should seek advice from the Named Nurse for Safeguarding Children in Children's Health Provision/ Named Midwife for North Lincolnshire and Goole NHS Foundation Trust to determine whether a referral to FFAP may be appropriate. It is important to note that if there is no consent or continued denial the practitioner must refer to FFAP in respect of safeguarding not only the school age child but also her unborn child.

GPS AND PRACTICE EMPLOYED STAFF

Women who are concealing are unlikely to present at GPs for pregnancy tests. However, they may present for other reason. As a matter of good practice, the possibility of pregnancy should be a prime consideration for GPs where nausea/vomiting is a key presenting symptom in a female patient who is of an age/development where sexual activity is possible. Appropriate examination and investigations should be performed.

In some instances, women may be genuinely unaware they are pregnant, but in others, the woman may be determined to conceal the fact, and may be extremely reluctant to agree to a pregnancy test or examination.

Where a GP has significant reason to believe a woman is pregnant, but she refuses all attempts to persuade her to undertake further investigations, further action needs to be taken. A discussion with the Designated Nurse for Named Midwife or Named GP for Safeguarding Children and liaison with the Midwife, Health Visitor or School Nurse (as appropriate) should take place. Where there are concerns about the potential welfare of the unborn child the GP should refer to FFAP.

Given that a previous concealed pregnancy indicates increased risk of further concealment, where this has been the case it should be documented within the GP records.

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

HEALTH VISITORS

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 predisposing 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.

As an initial step it may be helpful to discuss the matter with the Named Nurse for Safeguarding Children, GP and liaise with the Midwife to consider a way forward.

When faced with significant reason to believe a woman is pregnant, and yet in total denial, Health Visitors should discuss their concerns with the Named Nurse to determine whether a referral to FFAP may be appropriate.

MENTAL HEALTH AND LEARNING DISABILITY SERVICES

Professionals working in mental health and learning disability may be likely to be involved with a woman who is concealing a pregnancy. Mental illness, emotional problems, personality problems, a learning disability or substance misuse may all be contributory factors as to why some women conceal the fact that they are pregnant. If any professional working within these services identifies, or suspects a concealed pregnancy, they should seek to discuss this with their client, as appropriate, and contact their client's GP and midwifery services.

CHILDREN'S SOCIAL CARE

CONSENT TO REFERRAL

When a referral is made to FFAP regarding a suspicion of concealment, in particular where another professional believes the woman is denying a pregnancy, it is possible that the expectant mother will not have consented to the referral, or may not be aware. Good practice would require consent to, or the woman being made aware of the referral, unless doing so would place a recently born baby at risk of significant harm. It may not have been possible for referring agencies to seek consent for referral if there are fears the pregnant young person/ woman may disengage/ go missing if made aware of plan to refer.

REFERRALS WHERE 'EXPECTANT MOTHER' IS UNDER 16 (18 WITH ADDITIONAL VULNERABILITIES)

Referrals will be made due to potential risk to the unborn (or recently born) child and in respect of the mother if she is under 16, (or 18 if has additional vulnerabilities).

The referral to FFAP should be made, and recorded, in the name of the young girl if under 16 years (or 18 if there are additional vulnerabilities). An assessment of the needs of the young person and the unborn baby should be considered. When a young person under 16 is pregnant, there may be a criminal or child protection investigation to consider.

Where the 'expectant mother' is under 16, initial approaches should be made confidentially to the young woman to discuss concerns regarding the potential unborn child. She should be provided with the opportunity to satisfy social workers she is not pregnant, by undertaking appropriate medical examination or investigation, or to begin to make realistic plans for the baby, including informing her parents.

In the event the young woman refuses to engage in constructive discussion, and where parental involvement is considered necessary to address risk, the parent / main carer should be informed and plans made wherever possible to ensure the potential baby's welfare. Potential risks to the unborn child, or to the health of the young woman, would outweigh the young woman's right to confidentiality, if there was significant evidence that she was pregnant.

If a young person under 16 is thought to be pregnant but denying it, or concealing it, there could be many reasons for this. If the first approach to her is made by an education or health professional and this leads to a referral to FFAP, a Social Worker may need to consider speaking to her without her parent's knowledge in the first instance. She should be encouraged to undergo a pregnancy test or medical examination to confirm whether she is pregnant or not.

REFERRALS WHERE 'EXPECTANT MOTHER IS OVER 16

If the woman thought to be pregnant is over 16, the referral will be made in the name of the unborn baby and again, an Initial Assessment should be undertaken to consider the needs of both unborn baby and mother. FFAP should consider allocating the Initial Assessment to a worker with mental health expertise. If the case does not meet thresholds for statutory intervention then all efforts should be made to gain consent for a Single Assessment referral. See the Child Concern Model (see **Family Support Pathway and Threshold of Need Child Concern Model**).

Where the 'expectant mother' is over 16, every effort should be made to resolve the issue of whether she is pregnant or not. Clearly no woman can be forced to undergo a pregnancy test, nor any other medical examination, but in the event of refusal, social workers should proceed on the assumption that the woman is pregnant, until or unless it is proved otherwise, and endeavour to make plans to safeguard the baby's welfare at birth.

IN ALL CASES

A multi-agency meeting should be convened, involving GP, midwives, Named Nurse/ Midwife, and any other relevant agency to assess the information and to construct a plan. It may be appropriate to invite a representative from Mental Health Services (child or adult as appropriate) so that support, advice and/or consultation is available at an early stage.

Where there are additional concerns, e.g. lack of engagement, possibility of sexual abuse, domestic 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.

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An unborn child has no legal standing. Professionals cannot force an expectant mother to have any medical intervention at birth, unless she is deemed not to have Capacity. It is only possible to make appropriate contingency plans and to ensure that the woman/girl is fully aware of the consequences of her actions. In such circumstances, legal advice should be sought.

If a woman or young person has arrived at hospital, either in labour or following an unassisted birth, a referral must be made to FFAP. A referral should be initiated and a strategy meeting convened under Child Protection Enquiries.

The same analysis of risk should be applied to women who book late (after 24 weeks gestation), arrive in labour or following an unassisted delivery.

Where a baby has been harmed or has been abandoned, the referral should be made to FFAP immediately and an investigation under Section 47 of the Children Act should commence immediately. The Police must be notified immediately.

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

In undertaking an assessment the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child, as well as all the other aspects of the Assessment Framework, as these will be one of the key factors in determining risk.

Following an assessment it may be appropriate to refer the young girl/woman for psychological help. There clearly could be a number of issues for the young girl/woman which would benefit from psychological or psychiatric support. This might include Post Traumatic Stress Disorder, risk of postnatal depression, the impact if pregnancy was the result of abuse, the impact of denial of pregnancy, impact on parenting ability and emotional distress. A psychiatric assessment might be required in some circumstances; for example, if it is thought that the mother poses a risk to herself or to others.

POLICE

The Police will be notified of any Child Protection Enquiries made by Children's Social Care following a concealed pregnancy.

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 (mother or baby) has suffered or is at risk of significant harm.

If a child has been harmed, has died or been abandoned, child protection procedures will apply and a joint investigation will be conducted with Children's Social Care.

7. FUTURE PREGNANCIES

Where it is known there is a history of previous concealed pregnancy, a referral must be made by the practitioner to FFAP as soon as any subsequent pregnancy is known. Women who have already concealed a pregnancy are at a particular risk of doing so in the future. Children's Social Care may convene a multi-agency strategy meeting and make a plan to address any potential risk within a future pregnancy. Sharing information openly will be a critical factor in safeguarding the unborn child and professionals will need to accept this may be without the consent of the mother concerned.

A flow chart for consideration can be found at **Appendix E: Possibility of a Future Pregnancy when there has been a known Concealed or Denial of Pregnancy.**

8. LEGAL CONSIDERATIONS

UK law does not legislate for the rights of the unborn baby. In some circumstances, agencies or individuals are able to anticipate the likelihood of significant harm with regard to an expected baby. The fact that the law does not identify the unborn baby as a separate legal entity should not prevent plans being made and put into place to protect the baby from harm both during pregnancy and after the birth.

In certain instances, legal action may be available to secure medical intervention to protect the health and well-being of the mother and thereby, the unborn child. This may arise in cases where the young/ woman lacks Capacity due to mental illness (acute or chronic), learning difficulty, her young age or some other circumstance. The absence of support for intervention from parents or carers may be overcome by the use of legal intervention. It is only possible to make appropriate contingency plans and to ensure that the woman/girl is fully aware of the consequences of her actions. In such circumstances, legal advice should be sought.

Care proceedings cannot be instigated for an unborn child. They are not likely to provide a mechanism for intervening even where the mother is under 17 years. A child assessment order will require the pregnant young woman's agreement and the making of an interim care order will not transfer any rights to Children's Social Care to override the wishes of the young woman in relation to medical help. It may however provide a solution where the problem can be addressed by removing her from abusive carers to a safe environment such as foster care.

If legal steps need to be taken to protect a new-born baby, Children's Social Care will take the lead in consultation with North East Lincolnshire Council Legal Services. It is important to remember that even if the new mother is under the age of 16 she will still hold parental responsibility for the baby.

Acute medical services (maternity or A&E) may also need to seek urgent legal advice in order to safeguard the health of the woman in labour who does not cooperate with the medical intervention. Concealed birth (including concealed still birth) represents a criminal offence, though enquiries into these circumstances should be conducted sensitively and with due regard to the context in which this takes place.

Additional guidance and advice will be required if it is found that the mother may be a victim of trafficking and does not have legal status within the UK. Children's Social Care and the Police are classed as 'first responders' for making a referral to the National Referral Mechanism (NRM) to provide support and decision making.

9. RESEARCH EVIDENCE

Research carried out both nationally and within Lincolnshire (Earl et al 2000) has identified that concealed pregnancy may be associated with child protection concerns.

Concealed pregnancy may present in many ways:

- A person who may wish to deny the pregnancy due to concerns about the reactions of others;
- A person may have additional needs (physical, learning or emotional) which prevents them from realising or seeking proper antenatal care;
- A person may be prevented from seeking or receiving antenatal or post-natal care;
- A person may deny the existence of the pregnancy due to mental health or emotional needs.

For further research findings please see **Appendix B: Research Findings**.

10. ACKNOWLEDGEMENT

In developing the guidance for North East Lincolnshire Local Safeguarding Children Board (NELSCB) acknowledgement is made to West Sussex Safeguarding Children Board Concealed Pregnancy Good Practice Guide.

11. APPENDICES

Appendix A: Concealed Pregnancy Risk Indicators

Appendix B: Research Findings

Appendix C: Suspicions Arise that a Pregnancy may be Concealed or Denied

Appendix D: Concealment is Revealed

Appendix E: Possibility of a Future Pregnancy when there has been a known Concealed or Denial of Pregnancy

Appendix F: References