# Presentation of Concealed, Denied or Late Booking in Pregnancy or Where a Woman or Young Person is known to have Concealed, Denied or Booked Late in Pregnancy Previously

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| **Author** | **Maria Barnett / Adapted by Sandra Garner** |
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## 1. Introduction

This procedure is for anyone who may become aware of a woman or young person who:

(i) may be concealing or denying that she is pregnant;

(ii) has booked late during her pregnancy;

AND where this raises safeguarding concerns for her unborn child.

The concealment, denial or late booking in pregnancy can present a significant challenge to professionals in safeguarding the welfare and wellbeing of the fetus (unborn child) and the mother. While concealment, denial and late booking, by their very nature, limit the scope of professional help, better outcomes can be achieved by coordinating an effective inter-agency approach. This approach should begin as soon as the pregnancy (or birth) is suspected or confirmed.

This will also apply to future pregnancies where it is known or suspected that a previous pregnancy was concealed, denied or late booking occurred.

For the purpose of this policy and procedure any reference to ‘woman’ includes all females of childbearing age, including those under 18.

## 2. Definition

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 she is not accessing antenatal care; or when a pregnant woman tells another person or persons and they conceal the fact from all health agencies.

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 as not pregnant. In some cases a woman or

young person may be in denial of her pregnancy because of mental ill health, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005). Or there may be concerns regarding the ramifications that will/may occur if disclosure of the pregnancy is made.

For the purposes of this policy 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; as 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 particular stage of a woman's pregnancy.

## 3. Implications of a Concealed or Denied Pregnancy

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

Lack of antenatal care can mean that potential risks to mother and fetus may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or fetal 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.

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 the 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 and/or the antenatal booking contact, 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 and alcohol misuse; 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;
- Information should be given to women that is easily understood, including those with additional needs, learning difficulties or where English is not their first language. The information should be clear, consistent and backed up by current evidence / research;
- Women should be supported to feel able to disclose problems or discuss sensitive issues. Midwives need to be alert to the symptoms and signs of domestic violence and abuse and utilise routine enquiry.

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

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 and carries an increased risk of complications.

Where concealment is a result of alcohol or substance misuse there can be risks for the baby'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.

Concealment of pregnancy may also relate to mental health concerns or if a previous child has been removed or where there have been other previous and/or current safeguarding concerns.

## 4. Late Booking

If an appointment for antenatal care is made late (beyond 24 weeks), the reason for this must be explored and fully documented. Midwives and Obstetricians should consider the reasons for the woman booking late and make appropriate referrals to support her, such as to mental health services. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby and/or mother, if aged under 18 years, a referral to Children's Social Care must be made - see Part A, Chapter 2 **Referral and Assessment**. 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. Children's Social Care must also be involved in the following circumstances:

- The pregnant girl/young person and/or the baby's father is under the age of 13 in these cases the Police should also be informed;
- Both parents are between the ages of 13 and 16 years;
- Where there are concerns regarding the abuse of drugs and/or alcohol by the pregnant woman (or her partner or other relevant family members);
- Mother has been assessed as unlikely to be able to provide and to care for the child and herself;
- Mother is subject of Domestic Abuse or there is Domestic Abuse in the household;
- Mother is subject to or there are suspicions regarding Honour Based Abuse;
- Mother has been assessed as being unable to care/provide for the child due to her Learning Disabilities and/or Physical Disabilities;
- Mother is known to be experiencing or have a diagnosis of mental ill health;
- Mother is known to be at risk of Child Sexual Exploitation;
- Where a previous child/children has/have been removed;
- Where a previous pregnancy has been concealed or denied;
- Where a pregnant girl/young person is unsupported and/or homeless.
- Where there are current or historic child protection concerns.

- Where the mother (or her partner) are currently/have been assessed as a sexual risk to young children

Please also refer to Pre-Birth Assessment, Part A Chapter 2.6 for further information.

## 5. Process for all Un-booked Women Presenting in Labour

If a woman arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, these cases should be seen as high risk and an urgent referral must be made to Children's Social Care. If this is outside normal working hours then the Children's Social Care Emergency Duty Team must be informed.

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

Missing Unborn Notifications must be checked to see if the woman and unborn are known locally or to another Local Authority. The relevant Social Care Team must be notified immediately and any instructions on the notification followed.

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 immediately after the child is born.

In cases where there has been concealment or denial of pregnancy, especially where there has been unassisted delivery, a full assessment must be completed by health and Children's Social Care to ensure the woman receives the appropriate support and guidance following the birth. Where the mother is under 18 years of age this should include an assessment of her as a vulnerable child. The assessment may identify that the woman needs to be referred for a mental health assessment. If required this should ideally be done while the woman is an inpatient.

Contact should also be made to the mother's GP to share information about the current pregnancy and any historical concerns the GP may be aware of.

The baby, and mother if under 18 years of age, must not be discharged until relevant assessments have been completed and a Multi-agency Strategy or Discharge Planning Meeting has been held (see section 7).

The discharge summary from maternity services to the relevant GP must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks). This information must also be communicated to the health visitor.

## 6. Guidance for Educational Settings

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 or at least prompt a conversation with the young person regarding their welfare:

- Changes in appearance or behaviour
- Wearing uncharacteristically baggy clothing;
- Concerns expressed by friends;
- Repeated rumours around school or college;
- Refusal to participate in PE/sporting activities.
- Increased absences from school or sickness levels

Staff working in educational settings should try to encourage the pupil/student 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 Lead Person for Child Protection/Safeguarding in addressing these concerns.

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.

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 judgment and will be clearly dependent 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 of her parent's reaction, or there may be other aspects about the home circumstances that give rise to concern. Consideration should also be made regarding the possibility of the pregnancy resulting from child sexual abuse by a family member or by a person in a position of trust. If this is the case then a referral to Children's Social Care and the police should be made without speaking to the parents first - see Part A Chapter 2 Referral and assessment Also refer to the Part B, Chapter 39 **Honour Based Abuse Section** for relevant guidance.

If education staff engage with parents they need to bear in mind the possibility of the parent's collusion with the concealment, possibly due to child sexual abuse having resulted in the pregnancy. 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.

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 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 and/or that of her unborn child

## 7. Discharge Planning

A Multi-agency Discharge Meeting must take place to ensure a safe discharge from hospital for both the baby and the mother. An assessment of the child's needs, and an analysis of possible risks and parenting capacity in line with the Framework for

the Assessment of Children in Need and their Families should be carried out. This may result in several options including:

- an assessment under Section 17 of The Children Act (Child in Need) resulting in a Child in Need Plan;
- a Section 47 investigation resulting in a Child Protection Plan;
- provision of accommodation within Section 20 of The Children Act for the baby and/or mother;
- child and/or mother may be taken in to Police Protection;
- legal advice being sought;
- the child returning home with the parent with a robust discharge plan.

Post-natal care should be provided in line with the NICE Guidelines. The mother's GP, Community Midwife and Health Visitor must be included in all communications, invited to the relevant meetings and advised of the plan for the baby and mother on discharge.

## 8. Subsequent Pregnancies

If a woman is pregnant for a second or subsequent time and there is knowledge of a previous concealed pregnancy, a referral should be made to Children's Social Care and there should be a consideration of a Pre-Birth Assessment. See Pre-birth Assessment Part A, Chapter 2.6

## 9. Evidence from Research and Serious Case Reviews

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 had 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.

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.

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.

There are four studies that examine some of the psychological dimensions of concealed and denied pregnancy (Brezinkha, 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.

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.

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)

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 and/or partners has occurred to facilitate and encourage concealment of the pregnancy from those outside of the family or wider culture/community.

Concealment of pregnancy can also be driven by a specific belief system, where a faith group for example believes that the western health care systems should not be accessed by their group member as any health issues including births should be handled within the group and addressed by the power of prayers. All assessments should explore the beliefs of the parents and any possible impact on the care of the child.

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.

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