MK Together Multi-Agency Policy
Concealed and Denied Pregnancy

Concealed Pregnancy Policy	
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This is essential reading for professionals in all agencies and working as one in the MK Together Partnership. The aim of the Policy is to help identify girls, young women and women who might be at risk of concealing or denying pregnancy to ensure early support and onward referral is in place which will improve the outcome for mother and baby.

Contents

1. Introduction

The aim of this Policy is to inform professionals working in the MK Together Partnership how to identify and support girls, young women and women who may be concealing or denying their pregnancy. For the purpose of this Policy reference to girl, young woman or woman includes females of childbearing capacity.

It is intended to help promote awareness of concealed and denied pregnancy following a significant incident in Milton Keynes during 2018; in which a local child safeguarding practice review (LCSPR) was commissioned by the Milton Keynes Together Partnership following the death of a new-born full-term baby. The pregnancy and birth had been concealed by the young parents from their respective families and from health care services. The review made recommendations to raise awareness of concealed and denied pregnancy and for agencies to work together to assist with the identification, support and onward referral needed.

The Policy takes the stance that early identification of a concealed or denied pregnancy is optimal as research has shown that there are several negative outcomes associated with these pregnancies which can include an increased risk of death of the baby and negative outcomes for the mother including mental health needs.

It is imperative that agencies work together within the partnership and the Policy aims to raise awareness of services that can be provided to assist with the assessment of risk, additional vulnerabilities and support that can be accessed.

This Policy must be read in conjunction with;

- Milton Keynes Inter Agency Safeguarding Children Procedures
- Breaching Confidentiality on Consent to Share Information-Support Tool
- MK Together Safeguarding Adults Interagency Policy & Procedure

For the purpose of this Policy reference to girl, young woman or woman includes females of childbearing capacity (including under 18's). A pregnancy will not be considered to be concealed or denied for the purpose of this procedure until it is confirmed to be at least 24 weeks; which is the point of viability. However, because there may be behaviours to conceal or deny the pregnancy it may not always be possible for professionals to be certain of the stage of pregnancy.

2. Definition

A concealed pregnancy is when a girl, young woman or 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. The mother may tell other people they are pregnant but conceal the fact from all health professionals. The pregnancy may also be concealed from friends, family, school or educational establishment. In some cases, and especially where pregnancy may be seen as taboo; friends and families within the community may also conceal the pregnancy. (Spinelli, 2005, as cited in Greater Manchester Safeguarding 5.2.1 Concealed Pregnancies).

A denied pregnancy is when a girl, young woman or 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, there may be denial due to mental state, substance misuse or as a result of a history of loss of a child or children. (Spinelli, 2005, as cited in Greater Manchester Safeguarding 5.2.1 Concealed Pregnancies).

3. Background and Context

This Policy has been written following an incident in March 2018 in which young parents concealed a pregnancy from their family and health care services. Sadly, the mother gave birth without the help of health, midwifery or obstetric care and unfortunately this resulted in the baby's death. In order of putting this tragic event into context, this section will refer to some of the published research, findings from the local child safeguarding practice review and NICE Clinical guidelines to shine a light on the incidence, social context and perceived risk factors for concealed or denied pregnancies.

There are no definitive conclusions on the incidence of concealed pregnancy; however, it is noted to be considered a rare event generally. Nirmal 2006 and Wessel 2002 suggest that concealment might occur in about 1:2500 cases or 0.04% of all pregnancies. A study by Friedman S. 2007 showed 0.26% of all pregnancies in a sample of 31000 were to be concealed or denied. (Nirmal, Wessel and Friedman cited in the Greater Manchester Safeguarding 5.2.1 Concealed Pregnancies).

It is also difficult to identify the social groups which might be more at risk of a concealed or denied pregnancy. Wessel (2002) draws the conclusion that a 'stereotype' of an adolescent girl with poor social support and a history of either learning difficulties, mental health or drug and alcohol problems, is not helpful and not supported by the literature. Rather, pregnancy denial or concealment is a diverse condition associated with different psychological features. In their 1-year prospective study in Berlin, Wessel and colleagues recruited 65 women with a denied or concealed pregnancy and found that they had a median age of 27 years, 83% had a partner and 44 of the women had a previous pregnancy. They only found that 3 women had a psychiatric diagnosis of schizophrenia and just one who was abusing analgesics and tranquilizers. The authors concluded that a clear-cut typology of a 'pregnancy denier' could not be established. (Wessel and colleagues 2002 cited in Learning from a Concealed or Denied Pregnancy Finlay et al).

Similarly, a retrospective study in France over a five-year period also concluded a mother's median age was mid-twenties (26), with at least 3 children, half living with the father of the child. Perhaps more usefully, the researchers found that women had additional vulnerabilities such as low self-esteem and immaturity. (Tursz and Cook, 2010 cited in Greater Manchester Safeguarding 5.2.1 Concealed Pregnancies)

Murphy et al (2019) studied 30 young women who had concealed or denied their pregnancies in Ireland. In extensive interviews with the women they found that many women's relationships had been characterised by emotional, mental, sexual or physical violence and some had previous traumatic experiences such as child sexual abuse. Thus, women's previous traumatic experiences evoked the 'fear' response rendering women unable to access care or support needed. For some women fear related to a violent partner, parent or fear of a social reprisal also impacted on the coping responses of secrecy, silence and avoidance. Concealment in the review, is defined as 'internally' or 'externally' mediated. Internal concealment included cases where the young women or women had suffered sexual abuse as a child or who were in controlling relationships. Women 'internally' concealing up to birth were more likely to experience negative outcomes such as abandonment or neonaticide. Externally mediated factors included 'fear' responses to violent intimate partners, child protection services, poverty, lack of housing, finances and fear of reaction from employers. In

externally mediated cases, the researchers found that women were more likely to 'mother' at birth when external factors such as violence or lack of housing could be resolved.

The researchers concluded that understanding the typology of concealed pregnancy may assist practitioners in responding to women more sensitively, thus reducing the likelihood of further trauma from a concealed pregnancy. The importance of understanding previous traumatic experiences to improve services and care pathways to make them 'trauma sensitive' was also stressed. This was particularly important to reduce further issues women might experience such as further concealed pregnancies, psychological ill-health, self-harm and suicidal ideation and intent. (Murphy et al (2019) Regaining Agency & Autonomy: A Grounded Typology of Concealed Pregnancy. Dept of Nursing and Midwifery, University of Limerick, Ireland).

The link between concealed pregnancy and neonaticide or infanticide has also been identified in the research. In a study of 32 cases of infanticide in Finland it was found that in 91% of cases had been concealed and in 66% of cases women had a previous concealed pregnancy. (Putkonen H 2007). In a review of 40 Serious Case Reviews by the Department of Health in 2002, which included deaths into children or serious injury to children one death related to a concealed pregnancy.

The incidence between concealed pregnancy and mental health has also been explored; for example, Earl 2000 identified the link between concealed and denied pregnancy and psychotic illness which was said to be 13% of all known cases. (Earl 2000 cited in Greater Manchester Safeguarding 5.2.1 Concealed Pregnancies).

In the Local Child Safeguarding Practice Review (LCSPR) undertaken following a concealed pregnancy and significant incident; adverse childhood experiences (ACE) were referred to as a cluster of stressful or traumatic experiences that have significant impact on young people's emotional and psychological health, which also have implications for them in their adulthood. There are ten widely recognised ACEs identified since the 1990s which include abuse (physical, sexual and verbal), emotional and physical neglect (which is also abuse of a child), growing up in households where there are adults with substance abuse problems, mental health difficulties, domestic violence and an adult with a history of being in prison and/or parental separation. Co-occurrence of different or multiple ACEs represents multiple sources of risk and the potential impairment of a child's development. Additionally, other experiences such as bereavement, bullying, poverty and living in a deprived neighbourhood, anti-social and violent behaviour can also contribute to long term adversity represented in mental health and substance abuse. The young parents in the LCSPR had both been identified as having adverse childhood experiences. The young mother has emotional and psychological needs and the young father had been living in supported accommodation, had mental health and substance misuse needs and issues with relationships in the family had been problematic.

According to NICE guidelines for pregnancy and complex social factors the regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the woman and/or her unborn baby. The guidance also refers to the mental state of women using substances and anxiety about their pregnancy and feeling of guilt in using substances and the effect on their baby. The guidance also considers the impact of attitudes of healthcare staff and the potential role of social services which may increase women's anxiety and fear around their pregnancy. (Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors September 2010).

As part of the literature review, a search was undertaken to identify research which might link culture or religion with an increased risk for concealed or denied pregnancy. However, there was a lack of research which established this connection other than that of family honour or "izzat" within Asian cultures (Tighe & Lalor, 2015) and Shari'ah law (Islamic law), where unlawful sexual intercourse ("zina") may result in concealment

(Tønnessen & Al-Nagar (2019). It is more useful perhaps, to understand the individual factors as outlined in the research.

The literature is useful in understanding that there is not one clear social group at risk of a concealed or denied pregnancy; risk factors can transcend social grouping and it is helpful to keep a broad mind and professional curiosity irrespective of social group. Professionals should consider the history of abuse, impact of controlling social groups or relationships, low self-esteem, poor mental health, loss of a child or feared loss of a child, adverse childhood experiences and substance misuse and indeed any situation which might cause the fear response in being triggered which could lead to damaging and concealing behaviours.

The research is also useful in thinking about how agencies can be more 'trauma' informed, so that previous trauma and the impact of this can be recognised and services can develop 'trauma sensitive' pathways that are more informed of people's needs.

4.Reasons for concealment or denial of pregnancy

As outlined in the research; there are many different reasons why a girl, young woman or woman might conceal a pregnancy. It is important for practitioners to keep an open mind about this and consider vulnerabilities and situations which may cause 'fear' inducing anxieties and concealing behaviours.

Below are some examples of reasons for concealment for practitioners to consider; however, this is not an exhaustive list.

- Any abuse related traumatic experiences either as a child or adult including sexual or physical abuse, domestic violence or coercive control; including those who have been sexually abused and may be more likely to conceal the pregnancy through to birth holding additional risks for both mother and baby.

- Any traumatic experiences associated birth, miscarriage, still birth, death of a baby or children, fear of having children taken away by social services

- Cultural and religious considerations in which pregnancy or selection of partner may induce risk of honour-based violence

- Girls, young women or women at risk of financial exploitation and forced labour due to risk of coercive control or risk of harm from abuser, risk that pregnancy would be taken negatively

- Social/religious/cultural groups where beliefs around pregnancy or sex before marriage are taboo including social pressures on young girls from family, peers or school which might inhibit them to disclose or accept a pregnancy. In some social settings families and communities may also be involved in concealing a pregnancy.

- Young women and women with substance misuse needs due to fear of managing an addiction with a pregnancy and fear of involvement from authorities.

- Young women and woman with immature coping strategies may be more at risk of disassociating with their pregnancy.

- Any adverse childhood experience which may lead to stress or trauma response which can contribute to long term adversity.

There may also other situations due to learning needs or additional mental or physical disabilities in which pregnancy might be identified but which the mother does not realise and is not directly denying or concealing a pregnancy. It is helpful for practitioners to be aware of these circumstances and to keep an open mind to make sure that they are able to support in the most productive and caring way possible. Under the Equality Act 2010 any physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities is considered a disability.

In summary, it is important to use the information as described above as a guide for helping to identify a concealed or denied pregnancy; however, the practitioner should use professional curiosity to better understand individual situations, including any historic trauma or experiences and situations which might increase fear-based anxieties and risks for concealment or denial of pregnancy.

5.Outcomes of a Concealed or Denied Pregnancy

As described in section 3 'Background and Context', a concealed or denied pregnancy can lead to potentially fatal outcomes for both mother and/or baby regardless of intentions. An unassisted delivery can also be dangerous for both mother and baby, due to complications that can occur during labour and the delivery.

The lack of antenatal care may mean potential risks and complications are not detected. This includes complications of pregnancy, other health conditions and identifying foetal abnormalities. Young women and women taking medication for physical health and mental health conditions such as sodium valproate, may also not receive information about the effects of medication on the unborn child.

For girls, young women and women misusing substances, the concealment or denial of pregnancy can place the foetus at harm of normal development. Most drugs and alcohol can easily cross the placenta and cause abnormal brain and neurological development. Untreated drug or alcohol addiction can also be associated with poor nutrition and self-care which can also increase risks to the foetus and the mother. Addictions which include use of needles and risk of blood borne virus may also increase the risks of transmission to the foetus.

As described in the literature (Putkonen 2007 and DofH 2002) there is also a link between concealed or denied pregnancy and infanticide or neonaticide, so it is helpful to have this in general awareness. To re-iterate findings from Murphy et al 2019 the death of a baby is more likely when the concealment continues to birth, in their view girls, young women and women who have had a history of sexual abuse or controlling relationships are more likely to be in this group.

There is also a risk that the mother will be impacted from a mental health or psychological perspective, due to the trauma associated with concealing their pregnancy and fear of social stigma or fear of harm preventing them from disclosing their pregnancy. The mother might also have mental health needs due to any previous traumatic experience, which may be unresolved. Anxiety and stress might increase if risks around fear of sexual, physical or psychological abuse is increasing.

There may also be further negative implications for the girl, young woman or woman revealing a pregnancy due to fear of the reaction of family members or members of the community; this may put the mother or baby at a higher risk of further abuse or undue stress which can have a negative impact on both the mother and development of the baby.

The concealment or denial of pregnancy may indicate uncertainty towards the pregnancy and the future. Immature coping strategies and a tendency to dissociate from the situation are likely to have a significant

impact on bonding and parenting capacity. This may also include the ability to consider the baby's health needs and to form an emotional attachment following birth.

A concealed pregnancy and an unassisted delivery can be traumatic for the wider family, including the father and grandparents and without support can place families under additional stress.

6. Indicators

Mental health issues, distress, self-harming behaviours may indicate that the girl, young woman or woman is distressed and this should be considered an indicator that warrants professional curiosity and referral to appropriate agency for further support.

Disengagement may also be an indicator that the girl, young woman or woman is experiencing dissociation with their current situation or difficulty communicating. Again, professional curiosity is important to consider appropriate support.

The girl, young woman or woman might show signs of pregnancy physically with an increased weight gain or signs consistent with morning sickness. There may also be behaviours to conceal such as wearing uncharacteristically baggy clothing or attempts to try and loose weight.

In educational settings, there may also be rumours or concerns expressed by friends that the young person is pregnant. It is important that where suspicion is raised that this is followed up with the young person in a sensitive and supportive way.

7. Professional response to a concealed or denied pregnancy

The local child safeguarding practice review (LCSPR) undertaken in 2018 and following a case of a concealed pregnancy in MK identified several missed opportunities for professional intervention. The reviewers made a number of recommendations which should be implemented into every day practice across services in the MK Together Partnership. This includes the follow;

Partnership Working
Generally, partnership agencies and services operating within the partnership should have systems in place for staff training and awareness of risks relating to concealment or denial of pregnancy. There must be a focus in all services to provide more supportive environments for girls, young women and women. This includes operating a 'no blame' and supportive approach to understand risks around pregnancy and also concealed or denied pregnancy. This must also include being able to identify when there are safeguarding issues such as child sexual abuse, intimate relationships with minors and any child safeguarding issues affecting young fathers or young mothers. There must also be improved awareness of other support services that girls, young women, women or fathers may need to access including access to mental health, GP services, sexual health, drug and alcohol and access to support for financial advice and social housing.

Educational Settings
In School and Educational settings there should also be systems in place to identify those students who may have become pregnant or who are at risk of pregnancy. Again, the emphasis on the support in place cannot be highlighted enough. This may in part include services operating in schools such as Mental Health School Support teams, School Nursing and of course the school's own systems for pastoral support. Processes must be in place to identify any changes to behaviour or other indicators out of the ordinary which are worthy of follow up and this should also consider any referrals needed to safeguarding authorities.

Sexual Health

Young people's Sexual Health Services should also encourage more engagement with girls and young women particularly where risk indicators are noted. Systems must be in place to follow up to ensure that pregnant girls and young women access appropriate advice, help and support. Adult Sexual Health Services should also be aware of additional vulnerabilities which might place women at a higher risk of concealment or denial of pregnancy and ensure the support available helps women and signposts to other services which might be useful.

Social Housing

There are opportunities for Social Housing Services to identify young women and women who might demonstrate indicators such as changes in behaviour or physical changes that could indicate distress or possible concealment. Service should make sure that young women and women in need of advice, help and support arising from pregnancy are appropriately supported to improve their experience.

Drug and Alcohol Services

In the local Young People's Drug and Alcohol Service systems should be in place to identify additional response and support mechanisms in place to help girls, young women and women to feel supported and thus better able to disclose a pregnancy. Opportunities to identify concerns about intimate relationship with a minor are imperative and ensuring that safeguarding concerns are made in respect of either the girl, young women or young father.

7.1 Good Practice

It is good practice to enable the girl, young woman or woman to be able to talk freely and without condemnation if a concealed or denied pregnancy is suspected. Developing good relationships is an essential component to enabling trusted relationships to enable the person to express their feelings, anxieties and concerns which include the possibility of disclosing the pregnancy.

It is important to listen to the person and to take a supportive view and consider reasons why the pregnancy has been concealed or denied. It is helpful to identify any additional vulnerabilities or risks and talk these through in a supportive way with the person. It is important that the attitude of the practitioner does not trigger anxiety producing behaviours as this may influence dis-engagement.

The girl, young woman or woman may have additional support needs outside of the G.P and midwifery services and so it is good practice to think of wider health and social needs. This might include referrals to a range of services, such as children's or adult mental health services, domestic abuse services and services to meet a range of social needs. The more supported a girl, young woman or women feels about her pregnancy the more likely she will disclose and receive support.

Where any professional believes the expectant mother to be concealing or denying a pregnancy then as early as possible, they should sensitively enquire if she might be pregnant. It may be appropriate to identify a professional who has a good working relationship with the woman or young person to assist with the discussion and to provide reassurance to encourage contact with her GP and to take up offers of support for wider vulnerabilities

Even if the mother discloses her pregnancy and engages with health services, consideration of any additional support needs should always be considered as part of the assessment process.

It is imperative that appropriate referrals to Children's Social Care via the Multi-Agency Safeguarding Hub (MASH) is made where there are concerns about risk to the unborn child or identified abuse of a child. Contact with Adult Social Care should also be made should the women be deemed an 'adult at risk'. More information on referrals to statutory agencies and partners can be found in section 9.

8.0 Legal considerations

8.1 Gillick Competence and Fraser Guidelines

Both Gillick competency and Fraser guidelines refer to a legal case from the 1980s which looked at whether medical professionals should be able to give contraceptive advice or treatment to young people under 16-years-old without parental consent. Legally, Children under the age of 16 can consent to their own treatment if they are able to demonstrate a competence and full understanding of what's involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility must be able to consent for them.

Gillick competency applies mainly to medical advice but this can also be used by practitioners in other settings and is helpful for consideration when young people might need access to services but do not want parents or carers to know about it or has strong wishes which may conflict with parents' views. This means that even if the young person has informed their parents of the treatment they wish to receive but their parents do not agree with their decision, treatment can still proceed if the child has been assessed as Gillick competent.

While, there are no pre-defined questions to assess Gillick competency, several aspects do need to be considered such as the child's age, maturity, mental capacity, understanding of information or advice and ability to weigh up advantages, disadvantages, risks and benefits and the long-term impact and be able to articulate a rationale around their decision making.

Remember that consent is not valid if a young person is being pressured or influenced by someone else.

The process of Children's capacity to consent may be affected by different factors, for example stress, mental health conditions and the complexities of the decision they are making. The competency is also decision specific so while the same child may be considered Gillick competent to make one decision they may not be competent to make a different decision.

Professionals should consult parents where a child is not considered Gillick competent or if there are inconsistencies in their understanding.

Young people also have the right to seek a second opinion from another medical professional (General Medical Council, 2020). Gillick competency and Fraser guidelines NSPCC Learning online updated 10 June 2020

8.2 Fraser guidelines

The Fraser guidelines apply specifically to advice and treatment about contraception and sexual health. They may be used by a range of healthcare professionals working with under 16-year-olds, including doctors and nurse practitioners.

Following a legal ruling in 2006, Fraser guidelines can also be applied to advice and treatment for sexually transmitted infections and the termination of pregnancy (Axton v The Secretary of State for Health, 2006).

Professionals using the Fraser guidelines should be satisfied that the young person cannot be persuaded to inform their parents or carers that they are seeking this advice or treatment or to allow the professional to inform their parents or carers. The young person must also understand the advice being given and the professional must agree that it is in the young person's best interests or that they are likely to suffer physically or mentally if the treatment is not sought.

When using Fraser guidelines for issues relating to sexual health, it is Important that potential child safeguarding issues are considered. For example, it is illegal for children under 16 years to be sexually active and professionals will assess whether the young person's actions and decision making are Gillick competent and whether to involve safeguarding partners. Sexual activity may also be a possible indicator of child sexual exploitation and abuse. Sexual activity with a child under 13 should always result in a child protection referral. Child safeguarding concerns must always be shared with the Local authority and consideration should be given about this and any other historic concerns which may present a risk to the young person's safety or wellbeing. (Gillick competency and Fraser guidelines NSPCC Learning online updated 10 June 2020)

8.3 Confidentiality and sharing of information with other agencies

It is good practice to be open and honest with young people and adults when personal information about them needs to be shared with other agencies. In principle, it is always best practice to be able to get their consent for doing this but in practice this may not always be possible. There may also be additional risks identified with obtaining consent which might increase risks around child protection or place a vulnerable adult at an increased risk of harm.

The General Data Protection Act (GDPR) provides a number of bases for sharing personal information. This includes the exclusion of consent when sharing information that contains information to safeguard children or where individuals are placed at risk. (Information sharing and confidentiality MK Interagency Guidance – safeguarding children).

8.5 Mental Capacity

All interventions must comply with the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Professionals must consider whether a person over the age of 16 has the mental capacity to make informed choices, and is able to give informed consent, about all aspects of their pregnancy, safety and the safety of an unborn child. Section 9.1 (referral for child protection) and 9.3 (safeguarding adults) should also be read in conjunction with this section.

The MCA applies to people from the age of 16, and will continue to do so under the revised Code of Practice in the Liberty Protection Safeguards when they are enacted. The MCA states that a person lacks capacity if they are unable to make a decision due to an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter if the disturbance of the brain is permanent or temporary, and it may not be established merely on an aspect of behaviour which might lead professionals to believe unjustified assumptions about capacity. (Mental Capacity Act 2005 UK General Acts Legislation.gov.uk). Professionals should always assume that people have capacity, in the first instance, giving them every opportunity and assistance to help with the decision-making process. Where, a lack of capacity is suspected, a two-stage assessment must be undertaken which include an assessment of the mental impairment and of the decision-making process and person's the ability to make the decision.

Professionals should consider whether the person over the age of 16 has been able to make decisions relating to the pregnancy itself, or indeed whether they have been able to consent to having sex. Professional curiosity

is required to understand how someone over the age of 16 who lacks capacity to consent to sex became pregnant in the first instance. This of course may lead professionals into taking further action to safeguard the person and this may lead to police involvement.

Professionals may need to consider several aspects of pregnancy and decision making, including pregnancy or termination, childbirth, parenting and any related aspects of care. There are no inclusive lists of the decisions which might be important in this context; the professional should keep an open mind and be clear about the decision the person needs to make and their decision-making ability. Where there are doubts regarding a person's capacity a capacity assessment must be undertaken to assess decision making abilities.

Example of conditions which may affect capacity in this context might be; a person with a serious brain injury, psychotic illness or mental disorder, or the impact and symptoms of drugs or alcohol usage. Once an impairment or functioning of the brain is established, the professional must assess the person's ability to understand the decision considering how they are able to understand, retain and weigh up the decision needed and also how they can communicate their decision. It is imperative that all practical support is given to the person to enable them to make the decision and communicate this including any reasonable adjustments that might need to be made to help them understand or communicate the decision.

Best Interest Decisions and the Court of Appeal

If a person is assessed as lacking capacity to make a decision about any aspect of their pregnancy or birth then a best interest decision should be made. Professionals making a best interest decision should make sure they have undertaken a decision specific mental capacity assessment. The professional should do everything practicable to encourage and enable the person lacking capacity to engage in the best interest's process. This might include considering the person's past or present feelings, values or beliefs and any other factors the person might consider if they were making the decision themselves. It is important that the professional is aware of the possibility of discrimination, including the age, appearance, condition or behaviour of the person so not to discriminate in the best interest planning phase. It is important to consult others in the best interest planning process and this can include other professions, as well as close family or friends or people involved in the person's care. This will also include any one with a Lasting Power of Attorney or Enduring Power of Attorney made by the person. An independent Mental Capacity Advocate (IMCA) should also be considered for considerable medical decision making and where there are no family, friends or carers who might be able to advise. The professional should also consider the least restrictive form of decision making, to reduce undue restrictions on the person's life. The best interest decision making process, will consider all of the above factors as part of the process, weighing up these to make an informed best interest decision. (The Mental Capacity Act Code of Practice Best Interest Decision Chapter Five 64-67).

There are also those occasions when an onward referral is required to the Court of Protection and this may happen when a best interest decision cannot be agreed. For example, consider the where a 21-year-old woman diagnosed with agoraphobia and severe symptoms of anxiety when leaving the home, was considered to lack capacity about the decision to deliver her baby, at home or in hospital. The Trusts responsible for her care, one of which was her mental health Trust considered that the risks to her were too high if a home birth did not go to plan and if the woman needed to leave her home and go to hospital in the event of an emergency during labour. The Trust therefore applied to the court for endorsement of a plan which would see the mother transferred to hospital before she went into labour. While, the woman's view was considered as she was able to be present at the hearing but did not want to leave her home for a birth in hospital; the judge concluded it was in her and baby's best interests to have a plan in place for her to deliver in hospital as the risks were considered too high in the event of an emergency. The best interest plan included the option for a

mild sedation to be used to enable the woman to go to hospital and also the possibility of low-level restraint. However, the mother did go to hospital willingly for the birth of her baby. (Capacity, pregnancy, risk and the courts. Mental Capacity Law and Policy online 2021).

A further landmark case to consider, during 2019, is the case of a 24-year-old with a moderate learning disability. The person who had fallen pregnant while visiting family in Nigeria, and had cultural values which were against abortion. The medical professionals had undertaken a capacity assessment which concluded the person was not able to make a decision about whether to continue with her pregnancy or to have a termination of pregnancy. The application to the court stated that it would be in the patient's best interest to have a termination, due to difficulties and distress during pregnancy, birth and inability to ever look after the child. The judge overruled the application as the Trust were found to have not considered the cultural background of the patient and close family, the application did not clearly reflect the patient's wishes or feelings as part of the best interest decision. (Mental Capacity and the ability to make a decision about a termination of pregnancy Stephenson's.co.uk Law firm). Of course, in this particular example, there were also concerns regarding the person's ability to have ever consented to sexual intercourse.

Mental Capacity and Safeguarding

The professional should also consider if the person is an adult at risk; which is an adult who needs extra support because of their age, disability, physical or mental health and who may be unable to protect themselves from harm, neglect or exploitation. It must be recognised that harm can be caused by anyone who has power over another person, including family, friends, unpaid carers and health or social care workers. Abuse can also take various forms, including physical harm or neglect, and verbal, emotional or sexual abuse. Adults at risk can also be the victim of financial abuse from people they trust and abuse can also be carried out by individuals or by the organisation that employs people. (*MK Together Interagency Safeguarding Adults Policy V4 1st January 2021).*

If a woman who is defined as an adult at risk and has capacity to understand the implications of refusal of care relating to their pregnancy; the professional should consider if this is appropriate and where there is an aspect of public interest which puts other adults or children/the unborn child at risk of harm other interventions must be considered. This includes a referral to the Multi-Agency Safeguarding Hub (MASH) for child protection issues which are covered in section 9.1 and also a duty of care to intervene to protect the adult at risk via a safeguarding concern. The local authority may also need to consider whether the young woman or woman needs an independent advocate to help support with involvement in the process. Where, there is the immediate risk of harm, professionals should consider contacting the police or emergency services. (*MK Together Interagency Safeguarding Adults Policy V4 1st January 2021).*

9.0 Referrals and joint working with MK agencies and services

Following on from the incident in 2018 in which a concealed pregnancy resulted in the sad death of a baby; the MK Together Partnership set about working together to create a Policy which incorporated arrangements for working together. The following section, therefore contains information about working together and the support available for girls, young women and women concealing or denying pregnancy. The objective, as ever, is that early identification and support will improve outcomes to both the mother, unborn and born child.

9.1 Referral to Children's Social Care

A referral to children's social care may be required at any point in a pregnancy if as part of working with the girl, young woman or woman if a professional identifies that a pregnancy might be concealed or denied. This

also includes those cases where the encouragement to engage with health services has not worked and there may be additional vulnerabilities identified needing a multi-agency assessment. In these cases, a referral must be made to the Multi-Agency Safeguarding Hub (MASH). It is important that each agency keep contemporaneous records regarding such cases and that actions and timeframes are agreed, documented and shared between the professional and social worker. Clarity around who is responsible for which action and also how communication will be shared is imperative.

In cases where a girl, young woman or woman arrives at the hospital in labour, or mother and baby are admitted following an unassisted delivery and where medical or ante-natal care has not been accessed then the baby should not be discharged from hospital until a Multi-Agency Strategy Discussion has taken place. Any immediate risks must be assessed and a Multi-Agency Discharge Plan put in place.

There may also be circumstances where despite engagement with services and professionals there are vulnerabilities and risk factors that warrant a referral to discuss pre-birth planning as per the pre-birth pathway. A Multi-Agency Assessment will also be required to determine any risk factors to the baby, which will feed into the pre-birth assessment undertaken by Children's Social Care. An unborn baby case conference to manage any concerns may also be necessary.

United Kingdom law does not legislate for the rights of unborn children and therefore a foetus has no separate rights from its mother. Although a Local Authority is unable to assume parental responsibility for an unborn baby this should not prevent plans being made for the protection of the child, both during pregnancy and after birth.

Additional risk factors should also be considered as grounds for an immediate referral into Children's Social Care. If a young person is defined as a child (between 13 and 16) a referral is necessary and mandatory if the child is under the age of 13. Consideration should also be given if there is a history of substance misuse by the pregnant woman or by the father.

There may also be additional vulnerabilities to consider such as a history of mental health, substance misuse and any kind of abuse; including domestic, sexual, coercion, control, sex working or victims of modern slavery. Young women and women with physical or mental disabilities may also have additional needs in relation to parenting and so a referral to the MASH will be helpful for identifying the right support.

9.2 Involving the Police

The Police will be notified of any child protection concerns received by Children's Social Care where concealment or denial of pregnancy is indicated. However, where there is immediate concern of harm identified to the unborn child the police should be contacted immediately.

The mother and any other children in the household should also be considered as they may also need to be safeguarded. A visit to the family must be prioritised and not delayed or deferred for a Strategy Meetings to take place. The Social Care Emergency Duty Team can contact the Police out of hours and request that a welfare check is carried out or where an offence has been committed, the Police will need to investigate immediately to prevent a loss of evidence. The Police and Children's Social Care should jointly undertake visits where there are concerns for child's welfare.

During office hours and where professionals have concerns that need urgent follow up; the Multi-Agency Safeguarding Hub (MASH) should be contacted and consequently Police officers will be allocated to

investigate. Details of all offences or suspected offences must be reported to Police with urgency to safeguard those involved and for an investigation to commence.

9.3 Referral to Safeguarding Adults

The young women or women may be identified as an adult at risk; defined as an adult with extra support needs due to age, disability, physical or mental health and inability to protect themselves from harm, neglect or exploitation. Professionals should be aware that harm to an adult at risk can be caused by anyone with power over another person and this includes family, friends, unpaid carers and health or social care workers. Abuse takes various forms, including physical harm, neglect, verbal, emotional and sexual abuse. Adults at risk can be victim of financial abuse from people they trust and also by individuals or organisations that employ people. (*MK Together Interagency Safeguarding Adults Policy V4 1st January 2021).*

Where there are concerns there is a risk to the unborn child a referral to the Multi-Agency Safeguarding Hub (MASH) for child protection must be made. There is also a duty of care to intervene and protect the adult at risk via a safeguarding concern to Adult Social Care.

Professionals should consider how they make safeguarding personal, involving the adult at risk in decision making about the best course of action to protect, involve and have control over improvements to their quality of life, wellbeing and safety. Where, there is the immediate risk of harm, professionals should consider contacting the police or emergency services. (*MK Together Interagency Safeguarding Adults Policy V4 1st January 2021).*

9.4 Midwifery Services

Professionals may find it useful to consult with the safeguarding midwife to seek support to assist in engaging the young woman or woman with midwifery services and to confirm the pregnancy

If a pregnancy is confirmed by the woman then, professionals must encourage them to go to the GP to access antenatal care. The GP practice will help an expectant mother register with Midwifery Services for ultrasound scanning and advice about the pregnancy and birth.

If a young woman or woman discloses a pregnancy, she should be encouraged to register with Milton Keynes Maternity Services. Women can self-refer using the online Antenatal Self-Referral form on the Milton Keynes University Hospital Website.

If an appointment for antenatal care is made late (beyond 12 weeks), the reason for this must be explored. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby, a referral to Children's Social Care must be made. The young woman or 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. The midwife booking the pregnancy should commence a confidential communique and clearly document the conversation and current situation. The named Midwife for Safeguarding must be informed.

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 Children's Social Care. If this is in an evening, weekend or over a public holiday then the Emergency Duty Team Children’s Social Care must be informed.

Article 45 of the Nursing and Midwifery Order (applicable throughout the UK) makes it a criminal offence for anyone other than a registered midwife or doctor to 'attend' a woman during childbirth except in an emergency. Birth partners can support women but must not assume the role of a health professional.

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. The MKUFT abandoned baby policy must be followed for an abandoned baby.

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 share any concerns regarding parenting or maternal mental health. Any concerns must be clearly documented in the maternal notes and escalated to Children's Social Care, the Named Midwife for Safeguarding, and the Mental Health Team.

In cases where there has been concealment and denial of pregnancy the baby should not be discharged until a discharge planning meeting has been held and relevant assessments undertaken. A discharge summary from maternity services to the relevant GP must report if a pregnancy was concealed or denied.

Women are not obliged to accept any medical or midwifery care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity to make decisions for themselves. Medical professionals need to consider Gillick competency if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge.

9.5 CNWL NHS 0-19's Service (Health Visiting and School Nursing)

All information relating to referral and telephone access lines can be found on the CNWL website at www.cnwl.nhs.uk.

The 0-19's service is available for all pregnant women, children, families and young people in Milton Keynes. Services are provided within the integrated 0-19 team and include Health Visiting and School Nursing. The service aims to help to empower parents, children and young people to make decisions that affect their and their family's health, development and wellbeing.

The team consist of health visitors, school nurses, staff nurses, nursery nurses, healthcare assistants and administrators. Health visitors and school nurses are all qualified nurses or midwives who have undertaken specialist training in public health, child development and health needs assessment.

Health visitors can offer support and information to support all aspects health during pregnancy and in their first few weeks.

The team work in partnership with midwives, GPs and other professionals to support young women and women with any complications or difficulties experienced during pregnancy. The team provides enhanced support for women especially when identified as an adult at risk, or where there is a need for early help or child protection. The team work in partnership with the CNWL Named Nurse for Safeguarding Children and Named Professional for Safeguarding Adults.

9.6 Central and North West London (CNWL) Mental Health Services

All information relating to referral and telephone access lines can be found on the CNWL website at www.cnwl.nhs.uk.

As in all cases, where there is a serious concern about a young person's or an adult's mental health emergency support through Accident and Emergency should be sought.

The mental health of young women and women of childbearing age must always be considered by professionals to make sure that mothers receive the best possible support for their mental health and for the health and wellbeing of children and the wider family.

If the concerns for a woman's mental health are urgent in nature a referral should be made to the Mental Health Single Point of Access Team. If the referral is urgent, a member of staff from our crisis service will make contact. If the referral is not considered urgent initial assessments will then be made by the appropriate team, for example Perinatal Service.

If there are concerns for a young person's mental health a referral should be made to the Children and Adolescent Mental Health (CAMHS) Single Point of Access Team.

Perinatal Mental Health Service

Mental ill health during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members. Anxiety and depression are common before and after birth and women with pre-existing major mental disorders, such as schizophrenia, are at greater risk of compromised maternity care, delivery complications and relapse in the mental health during pregnancy and the postpartum period. Pre-existing bipolar disorder, other serious affective disorders and personal history of puerperal psychosis predicts a 50% risk of early postpartum major mental illness. The perinatal period is defined here as pregnancy and the first 12 months following childbirth. In line with the NHSE Long Term Plan the service will move towards offering support

CWNL Milton Keynes Community Perinatal Mental Health Service (PMHS) operates across MK to provide assessment, specialist support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services. The service is part of the local integrated care pathway across BLMK (Bedfordshire, Luton and Milton Keynes).

The service work with mothers under the age of 18 years if significant perinatal mental illness dominates their presentation. In these circumstances the assessment, treatment and management of a young mother is undertaken in collaboration with the Perinatal, CAMHS and Social Services. The team also work in partnership with the CNWL Named Nurse for Safeguarding Children and Named Professional for Safeguarding Adults to ensure support is given to practitioners, and to discuss concerns around any vulnerability and the infant's mental health. Together with the Health Visitor and extended primary care team, the team work to ensure the optimal physical, emotional, cognitive and social development of the baby. The team only accept referrals from health and social care professionals.

Children and Adolescent Mental Health Services (CAMHS)

Milton Keynes Specialist CAMHS provides assessment and treatment to children and young people up to the age of 18, their parents/carers and their families. Referrals are welcomed when children and young people are presenting with a significant level of concern regarding their mood, behavior and general presentation.

The CAMHS team offer a telephone referral service which is open to professionals and young people whether known to the service or not.

CAMHS aim to give priority appointments for urgent referrals within 4 weeks and non-urgent referrals are placed on a waiting list which is reviewed frequently.

When there are significant concerns about a young person's welfare e.g. serious self-harm or suicidal intentions the young person should be taken to A&E where they will be seen by a member of the CAMHS Liaison and Intensive Support Team (LIST).

9.7 Drug and Alcohol services

CNWL Adult Drug and Alcohol Services – MK ARC

The service helps people break a cycle of addiction to substances such as heroin, cocaine, and new psychoactive substance as well as long term alcohol or gambling addictions. The service work with people at any stage of their alcohol, drug or gambling difficulties to provide a single point of access to assessment and treatment for problems. The team recognise the importance of providing treatment for both the substance misuse problem, as well as any associated emotional and mental health issues.

Milton Keynes Young People Drug and Alcohol Service

Milton Keynes Young Peoples Drug and Alcohol Service support anyone up to age 18 (or up to 25 if there are additional needs). Young people can access the service if they have been affected by someone else`s substance use, or would like advice and information about substances so they can make more informed choices, or need help to reduce/stop their own substance use. The staff are knowledgeable and caring and offer a free, non- judgemental, individualised and integrated service.

9.9 Sexual Health Services

In cases where there is concern that a girl, young woman or woman might be concealing a pregnancy or in cases where a pregnancy is confirmed but there are additional risk factors identified; a referral to the MASH for further assessment will be made. The team will also work closely with named professionals working within the service to safeguard the needs of children and vulnerable adults. For any immediate concerns of harm to mother or unborn baby professionals working in sexual health are encouraged to contact the Police.

9.10 MKACT Domestic Abuse Services

The service has systems in place to help identify risks around concealment or denial of pregnancy which include a review of all women on the caseload to discuss safeguarding concerns and risk of pregnancy concealment or denial and discussion about possible support. If it is identified that the woman has a concealed or denied pregnancy a support session would be arranged to talk through this and to sensitively discuss support that could be given. The team also actively encourage all woman to access health services in relation to pregnancy and offer support to attend any appointments. Referrals to appropriate statutory agencies are followed as part of local processes.

10. Conclusion

This multi-agency policy has reflected upon current research and also learning following an incident of concealment in Milton Keynes during 2018 to better understand the reasons why girls, young women and

women might conceal or deny a pregnancy. It has been acknowledged that there are many reasons why this might happen but with particular reference and importance it is to consider the role that fear and anxiety may play in influencing behaviours to conceal or deny pregnancy. It is therefore, with the upmost importance that the professional is curious about the possibility of a concealed or denied pregnancy, especially when there are other indicators such as a change in behaviour or known factors which might put the girl, young woman or woman at a higher risk of a concealed or denied pregnancy.

To assist with improving outcomes, the best possible approach, is the early identification of the pregnancy to enable a supportive and understanding approach to be taken, thus reducing the risk of further behaviours to conceal. The early identification, also gives more time for thorough assessment through the Multi-Agency Safeguarding Hub (MASH), Adult Social Care and partner agencies to ensure appropriate support for antenatal, post-natal and additional needs is in place; this also includes the identification of additional risks such as domestic or sexual abuse so that appropriate interventions are made.

The MK Together Partnership Agencies worked together to produce this Policy and Procedure. The Partners are asked to put the policy into practice by sharing the information widely with staff and ensuring that agency procedures reflect the need to identify, support and refer accordingly in the event of a concealed or denied pregnancy.

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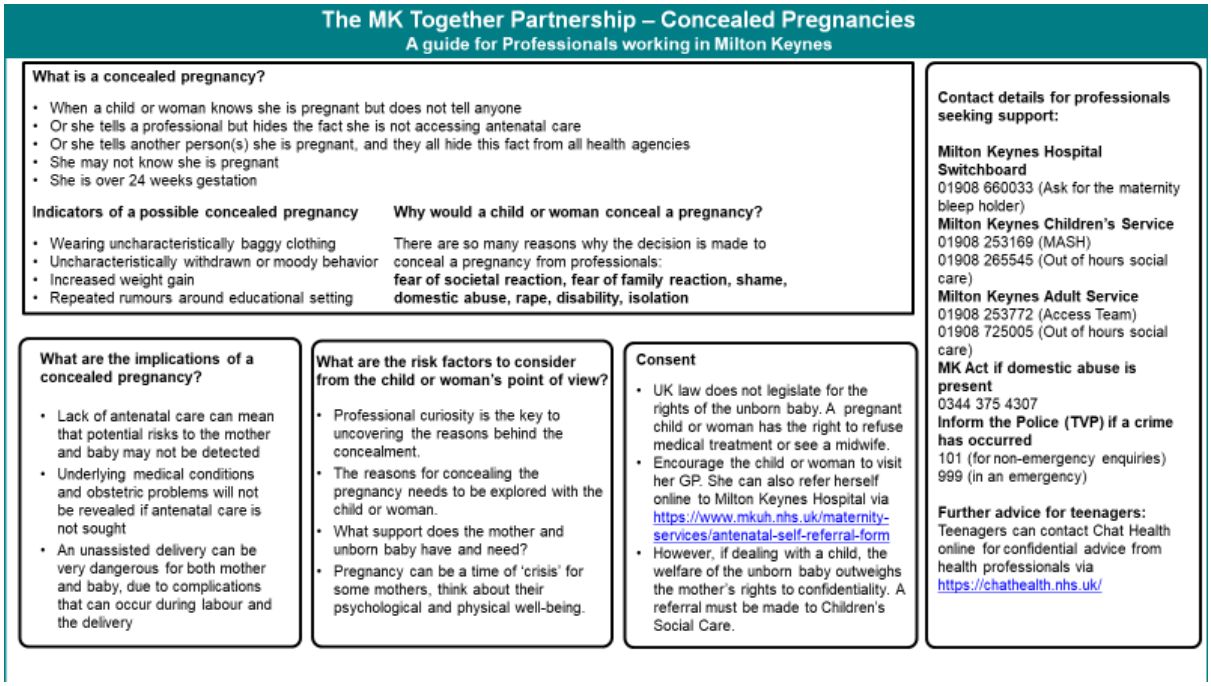

The MK Together Partnership – Concealed Pregnancies
A guide for Professionals working in Milton Keynes

What is a concealed pregnancy?

- When a child or woman knows she is pregnant but does not tell anyone
- Or she tells a professional but hides the fact she is not accessing antenatal care
- Or she tells another person(s) she is pregnant, and they all hide this fact from all health agencies
- She may not know she is pregnant
- She is over 24 weeks gestation

Indicators of a possible concealed pregnancy

- Wearing uncharacteristically baggy clothing
- Uncharacteristically withdrawn or moody behavior
- Increased weight gain
- Repeated rumours around educational setting

Why would a child or woman conceal a pregnancy?

There are so many reasons why the decision is made to conceal a pregnancy from professionals:
fear of societal reaction, fear of family reaction, shame, domestic abuse, rape, disability, isolation

What are the implications of a concealed pregnancy?

- Lack of antenatal care can mean that potential risks to the mother and baby may not be detected
- 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

What are the risk factors to consider from the child or woman's point of view?

- Professional curiosity is the key to uncovering the reasons behind the concealment.
- The reasons for concealing the pregnancy needs to be explored with the child or woman.
- What support does the mother and unborn baby have and need?
- Pregnancy can be a time of 'crisis' for some mothers, think about their psychological and physical well-being.

Consent

- UK law does not legislate for the rights of the unborn baby. A pregnant child or woman has the right to refuse medical treatment or see a midwife.
- Encourage the child or woman to visit her GP. She can also refer herself online to Milton Keynes Hospital via https://www.mkuh.nhs.uk/maternity-services/antenatal-self-referral-form
- However, if dealing with a child, the welfare of the unborn baby outweighs the mother's rights to confidentiality. A referral must be made to Children's Social Care.

Contact details for professionals seeking support:

Milton Keynes Hospital Switchboard
01908 660033 (Ask for the maternity bleep holder)
Milton Keynes Children's Service
01908 253169 (MASH)
01908 265545 (Out of hours social care)
Milton Keynes Adult Service
01908 253772 (Access Team)
01908 725005 (Out of hours social care)
MK Act if domestic abuse is present
0344 375 4307
Inform the Police (TVP) if a crime has occurred
101 (for non-emergency enquiries)
999 (in an emergency)

Further advice for teenagers:
Teenagers can contact Chat Health online for confidential advice from health professionals via https://chathealth.nhs.uk/