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Staffordshire and Stoke-on-Trent Safeguarding Children Boards

PROCEEDURES FOR CHILDREN IN SPECIFIC CIRCUMSTANCES

CONCEALED PREGNANCY AND BIRTH

Section 4D (Staffordshire)

Section D13 (Stoke-on-Trent)

Contents:

- 1. Purpose of the guidance**
- 2. Definition**
- 3. Reason for concealment: research evidence**
- 4. National and local context**
- 5. Implications of a concealed pregnancy**
- 6. Risks and protection issues**
- 7. What to do should you have concerns**
- 8. When concealment is revealed**
- 9. Future pregnancies**
- 10. Legal considerations**
- 11. Specific Agency Responsibilities**
- 12. Reference**
- 13. Appendices**

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1. Purpose of the guidance

- 1.1 This guidance is intended for professionals¹ who may encounter females² who conceal the fact that they are pregnant or where there is a known previous concealed pregnancy³.
- 1.2 This guidance should be applied in conjunction with SSCB and Stoke SCB Inter Agency procedures where relevant. These can be accessed by following the links to:

Staffordshire: www.staffsscb.org.uk/procedures

Stoke-on-Trent : www.safeguardingchildren.stoke.gov.uk

- 1.3 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 approach⁴ once the fact of the pregnancy is established. It is of particular importance when females are considering future pregnancies where there has been a previous concealed pregnancy with a clear emphasis of safeguarding the unborn child (Please see footnote 2). 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.

2. Definition

- 2.1 A concealed pregnancy is when a female knows she is pregnant but does not tell anyone or those who are told conceal the fact from all agencies. Consideration should also be given if a female appears genuinely not aware that she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought. In exceptional cases the mother may not reveal the delivery and may conceal the baby even if it has died.
- 2.2 Concealment of pregnancy may come to light late in pregnancy, in labour or following delivery. The birth may be unassisted whereby there are additional risks to the child and mother's welfare and long-term outcomes.

¹ Throughout this policy, the term professional is used to describe any person that comes into contact with a female who is pregnant/ recently had a child. This will include any person working within the voluntary and private sector and covers both children's and adult services.

² This may be a child or an adult.

³ Where it is known that there has been a previously concealed pregnancy, professionals should be alert to any concerns which would increase the risk to the unborn child and the mother. Therefore any assessment would need to thoroughly analyse these concerns, supported by any information provided by any other service (whether this is adults or children) involved with the mother/ family

⁴ Working Together 2015

2.3 Child protection issues may arise where a pregnancy is disclosed late as the focus is on the child regardless of whether unborn or born.

2.4 For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy.

3. Reason for concealment: research evidence

3.1 There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that females may have a variety of reasons for their behaviour.

3.2 Reder et al (1993) summarised thirty-five major child death inquiries and highlighted evidence of considerable ambivalence to or rejection of some of those pregnancies and a significant number with little or no antenatal care. They also draw attention to 'the meaning of the child'. Reder & Duncan (1999) reinforce their previous evidence in a follow-up study but 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. 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 (2003), highlight that there is a well-established link between neonaticide;(infanticide in the 24 hours following birth) and concealed pregnancy⁵.

3.3 Studies have shown that late commencement of antenatal care may be a feature of teenage pregnancy, for a variety of reasons. These include not fully understanding the consequences and complications of risk factors in pregnancy, poor motivation to keep appointments, concealment or denial of pregnancy.

3.4 In some cases the female may be truly unaware that she is pregnant until very late into the pregnancy. For example a female with a learning disability may not understand why her body is changing.

3.5 Denial may persist as a result of thinking that the problem will go away if it is ignored.

3.6 Due to stigma, shame or fear, concealment may be a deliberate means of coping with the pregnancy without informing anyone.

3.7 A female 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.

⁵ Saving Mothers Lives Dec 2007. CEMACH LONDON. Reviewing maternal deaths to make motherhood safer 2003-05. "many females with socially complex pregnancies were known to social services, and/or child protection services. Not only did some try to conceal their pregnancies from social services, but many females also avoided maternity care".

- 3.8 A female who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant.
- 3.9 There have been cases where the mother not only conceals the pregnancy and birth, but also the baby's body, should the baby die. 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.
- 3.10 A pregnancy may be concealed in situations of domestic abuse. Domestic abuse is more likely to begin or escalate during pregnancy.
- 3.11 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 female involved. This can create a significant pressure on a female to seek to conceal a pregnancy or for the psychological conditions to be present where a pregnancy is denied. In some local and national cases collusion between family or partners has occurred to facilitate and encourage concealment of the pregnancy from those outside of the family or wider culture/community.
- 3.12 'Freebirthing' is growing in popularity in the United States and has been reported in the UK (The Royal College of Obstetricians 2008). 'Freebirth' is where a female chooses to give birth alone. In some instances, the female were reported to engage in antenatal care, but others chose to avoid all antenatal care whatsoever. Whilst the RCOG fully supports normal birth and believes that every female should have the right to give birth in an environment in which she feels comfortable, the safety and wellbeing of the mother and baby is paramount. Before choosing a place of birth all female should be fully informed of the potential risks, which may include the need for intervention, transfer to hospital and/or pain relief. Obstetricians and midwives are concerned with the safety of patients, mother and child⁶.

The RCOG stress that at present, the practice of Freebirth is new to the UK and little research exists regarding its safety and success.

- 3.13 The DfES published a research report in 2006 that highlights links of child abuse to 'possession and witchcraft'. In some parts of the UK, this has been identified as a concern. A female may become pregnant but conceal the fact for fear that the baby may be taken from her (Stobart 2006).
- 3.14 Practitioners should be alert to a potential future pattern of concealed pregnancies once one has been identified. To assess the longer-term prognosis

⁶ <http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-unassisted-childbirth-or-freebirth>

for the child it is important to gain understanding of what outcome the mother intended for the child i.e. did she hope it would survive?

3.15 There are four known studies that look at some of the psychological dimensions of concealed (or denied) pregnancy (Brezinka et al 1994, Earl et al 2000, Moyer 2006, Spielvogel & Hohener 1995). Moyer (2006) draws attention to research findings that the majority of female who are in denial about pregnancy or who have concealed the pregnancy from others typically leave hospital without the consideration of a mental health assessment. The paper highlights that denial or concealment of pregnancy should be a 'red flag' and that for such female a full psychiatric assessment is indicated.

3.16 A female may conceal a pregnancy or birth for reasons that are completely unknown.

4. National and local context

4.1 There is very little national or local research in relation to concealed pregnancies available. A small number of studies have attempted to identify how frequently phenomenon of concealment occurs (Nirmal et al 2006, Wessel & Buscher 2002). These suggest that concealment (through to delivery) might occur in about 1:2500 cases. Following several Serious Case Reviews, Lincolnshire recognised the significance of concealed pregnancy and commissioned a piece of research (Earl et al 2000) and subsequently developed a set of risk indicators (see appendix 2).

4.2 As far as is known, the majority of babies born of concealed pregnancy are healthy and go home with their mothers. However, little is known about the long-term outcomes for children and families of concealed or late booking pregnancies.

4.3 It is the duty of all agencies to consider the safety of the mother and the unborn child (and any other children in her care). Any child protection concerns must be referred to Children's Social Care in accordance with the Staffordshire and Stoke-on-Trent Safeguarding Children Board Inter Agency Procedures.

5. Implications of a concealed pregnancy

5.1 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 female 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 solely a teenage phenomenon. Nirmal et al (2006) identified preponderance of concealed pregnancies during the winter months. Previous concealed pregnancy may also be regarded as an important indicator in predicting risk of a future pregnancy being concealed with a harmful outcome for the child.

5.2 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

5.3 There could be a number of reasons why female fear that they will be separated from their child. Research evidence suggests that substance-misusing female 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.

6. Risks and protection issues

6.1 For a comprehensive list of risk factors to consider when dealing with Concealed Pregnancy please see Appendix B

6.2 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.

6.3 The implications of concealment are wide-ranging. Concealment of a pregnancy can lead to a fatal outcome for both mother and child, regardless of the mother's intention.

6.4 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.

6.5 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.

6.6 The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected.

6.7 Underlying medical conditions and obstetric problems will not be revealed.

6.8 An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery.

6.9 Other possible implications for the child arising from mother's behaviour could be a lack of willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth.

- 6.10 Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently. There are also risks to the unborn baby from prescribed medications.
- 6.11 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 female's partner.

7. What to do should you have concerns

- 7.1 This section outlines actions to be taken when a concealed or denied pregnancy is suspected (see **Section 2, Definition** and **Appendix A**). If a pregnancy is suspected of being concealed or denied, the female should be strongly encouraged to go to her GP, maternity services or midwife to access ante-natal care. The GP, maternity services or midwife practice will help a female register with maternity services for ultrasound scanning and advice about pregnancy and birth.
- 7.2 Every effort should be made by the person alerted to suspicion of concealed pregnancy to encourage the female to obtain medical advice. If the response shows that this is unlikely, or that there is any indication of the risks to the unborn baby increasing then a referral should be made to the relevant Children's Social Care Department so that effective service responses may be coordinated⁷.

Staffordshire's First Response Team on 0800 1313 126

Stoke-on-Trent's Safeguarding Referral Team 01782 235100.

Referrals can also be made to the MASH (Multi Agency Safeguarding Hub) police on 101.

- 7.3 If concerns are such that a Child Protection referral needs to be made, it will be made on the unborn child. If the expectant mother is under 18 years, consideration will be given to whether she is a **Child in Need or subject of Section 47 enquiries**. In addition, if she is less than 16 years then a criminal offence may have been committed and this needs to be investigated.

⁷ The following documents offer advice and guidance on the referral process including practice issues with regard to gaining consent

[Staffordshire's 'Accessing the Right Help at the Right Time'](#)

[Stoke-on-Trent's Guide to Levels of Need](#)

8. When concealment is revealed

- 8.1 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. It should be noted that social workers should undertake an assessment for an unborn baby where there are concerns in accordance with the local thresholds for statutory intervention and the guidance contained in Working Together to Safeguard Children 2015 (paragraph 38).
- 8.2 Where a concealed pregnancy is identified⁸, 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.
- 8.3 A referral to Staffordshire's First Response Team / Stoke-on-Trent's Safeguarding Referral Team must always be made where there are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care, non-co-operation with necessary services, noncompliance with treatment with potentially detrimental effects for the unborn baby or already known to/ engaged with children's social care.
- 8.4 In cases of full concealment followed by unassisted delivery, Staffordshire's First Response Team / Stoke-on-Trent's Safeguarding Referral Team must always be informed and a full psychiatric assessment considered jointly by the agencies.
- 8.5 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

9. Future pregnancies

- 9.1 Where it is known that there is history of previous concealed pregnancy, consideration must be given to the risk factors and discussion must take place with the designated child protection professional within the professionals own organisation. Where this discussion highlights risks or additional concerns a referral must be made to the relevant Staffordshire's First Response Team / Stoke-on-Trent's Safeguarding Referral Team. Sharing information openly will be

⁸ Earl et al's study (2000) concluded that there are 'potentially serious child protection outcomes for the child as a result of a concealed pregnancy' and that a detailed multi-agency assessment should be undertaken.

a critical factor in safeguarding the unborn child and professionals will need to accept this may be without the consent of the mother concerned⁹.

9.2 Following a concealed pregnancy where significant risk has been identified, Staffordshire's First Response Team / Stoke-on-Trent's Safeguarding Referral Team should take the lead in developing a multi-agency plan, to address the possibility of a future pregnancy.

9.3 Where there is a known plan in place, it should be activated as soon as professionals become aware of a subsequent pregnancy.

10. Legal considerations

10.1 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. However for social workers the guidance set out in paragraph 8.1 applies in respect of social workers needing to undertake an assessment on an unborn baby where there are concerns, in accordance with local thresholds and Working Together to Safeguard Children 2015 (paragraph 38).

10.2 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 female lacks capacity due to mental illness (acute or chronic), learning disability, her age or some other circumstance. The absence of support for intervention from parents or carers may be overcome by the use of legal intervention. These measures can be obtained in an emergency by application to the High Court. It is only possible to make appropriate contingency plans and to ensure that the person is fully aware of the consequences of her actions. In such circumstances, legal advice should be sought. In exceptional circumstances where there is insufficient time to seek an Emergency Protection Order (EPO) and a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm the use of Police Protection Powers (PPP) should be considered.

10.3 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 female's agreement and the making of an interim care order will not transfer any rights to the local authority to override the wishes of the female 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.

10.4 If legal steps need to be taken to protect a new born baby, the relevant Children's Social Care Department will be responsible for this. Acute medical services

⁹ Further guidance on sharing information can be found at <http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0072915/information-sharing>

(maternity or A&E) may also need to seek urgent legal advice in order to safeguard the health of the female in labour who does not cooperate with the medical intervention.

11. Specific Agency Responsibilities

11.1 Midwives

If an appointment is made very late for antenatal care, the reason for this must be explored. If there is a cause for concern a referral should be made to Children's Services. The female must be informed that the referral has been made, unless there are significant child protection concerns.

If a female arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, a referral should always be made to Children's Services. If the female arrives at a non Staffordshire Hospital, referral should be made to the area Children's Services office in the area in which they reside.

If the baby arrives at the weekend/bank holiday/out of hours the appropriate

Emergency Duty Team should be contacted:

Stoke-on-Trent - 01782 234234 between 5pm and 8.30am Monday to Thursday and from 4.30pm – 8.30am Friday

24 hour service available during weekends and bank holidays

Staffordshire – 0345 604 2889 between 5pm and 8.30am Monday to Thursday and from 4.30pm – 8.30am Friday

24 hour service available during weekends and bank holidays

If the baby had been harmed in any way, or abandoned as a result of the mother's actions, a referral must be made to children's social care and the Police must be informed.

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

Where the referral is received out of hours, in relation to a baby born as the result of a concealed pregnancy, the **Emergency Duty Team (for either Stoke-on-Trent or Staffordshire)** will take steps to prevent the baby being discharged from hospital until an assessment has been undertaken. In normal circumstances this would be through a voluntary agreement, though clearly there could be circumstances in which it would be appropriate to apply for an Emergency Protection Order, or to seek the assistance of the Police in preventing the child from being removed from the hospital.

11.2 Children's Social Care

Contact details below are to be used between 8.30am -5pm Monday to Thursday and between 8.30am and 4.30pm on Fridays

Stoke-on-Trent's Safeguarding Referral Team – normal office hours: 01782 235100

Staffordshire First Response Team – normal office hours: 0800 13 13 126

You can also contact the and Multi Agency Service Hub (MASH) which is where a range of professionals are based including Staffordshire First Response Team and Staffordshire Police Child Protection Team.

MASH – please dial 101 and ask for MASH

In relation to referrals where there are concerns about late booking for ante-natal care at Staffordshire Hospitals, a social worker will be responsible for undertaking an assessment on a "Child in Need" basis unless there is significant information to suggest that the child protection procedures should be invoked.

The social worker will respond to referrals where a female has arrived in labour or has been admitted following an unassisted birth. An assessment will be conducted and the child protection procedures initiated. Lateral checks will be completed. The potential need for a Child Protection Conference should be considered. Where a baby has been harmed, has died or has been abandoned, the referral will be managed by the child protection procedures being invoked.

In undertaking an assessment the social worker will need to focus on the reasons why the pregnancy was concealed. Please see Concealed Pregnancy Checklist (Appendix B) as well as all the other aspects of the Assessment Framework, as this will be one of the key factors in determining risk.

Following an assessment it may be appropriate to refer the female for psychological help. There clearly could be a number of issues for the young female which would benefit from psychological support.

This might include Post Traumatic Stress Disorder, risk of post-natal depression, the effect if pregnancy was 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, such as complete denial of pregnancy.

11.3 Police

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

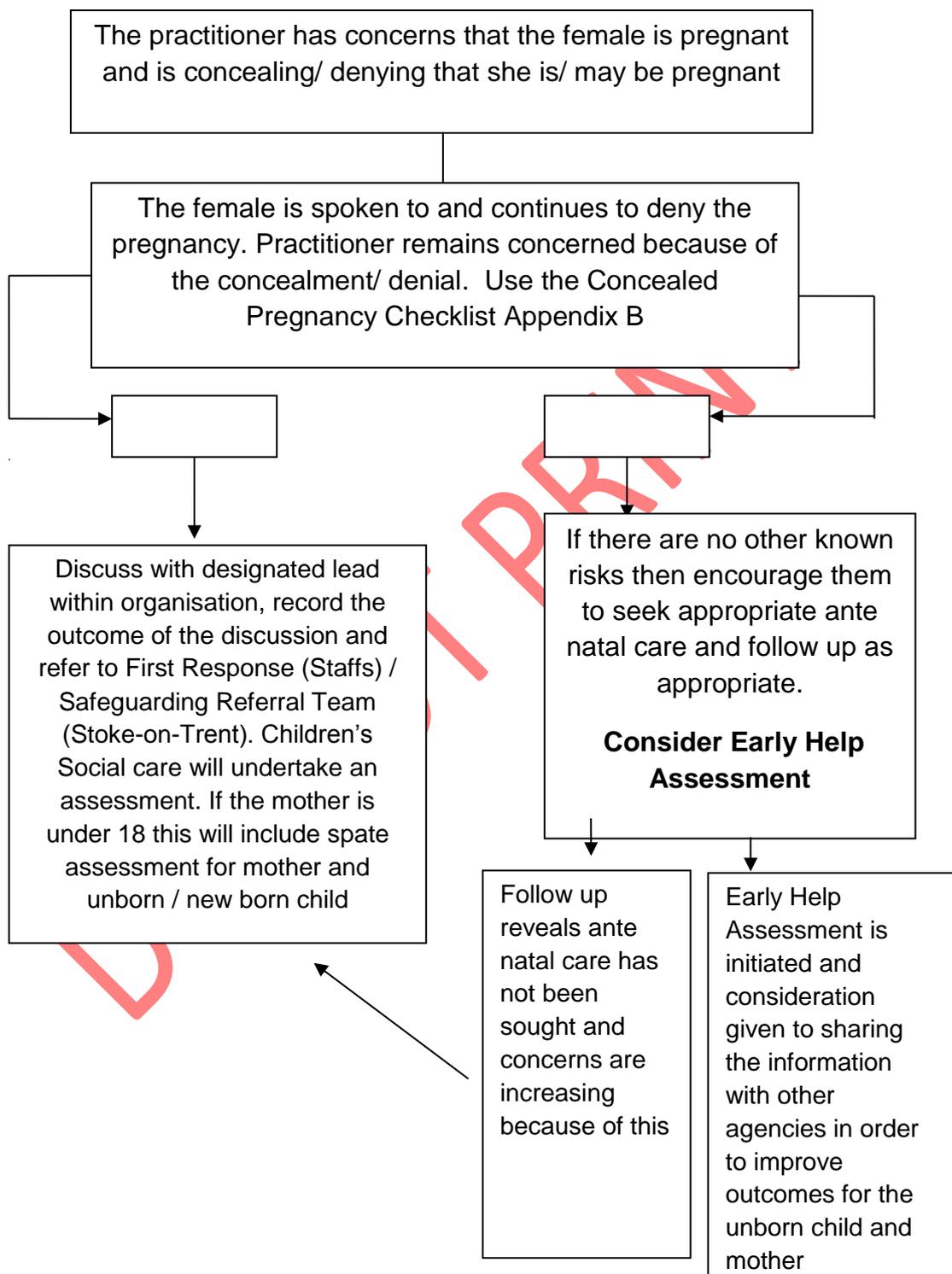
Consideration will be given to whether a joint investigation is needed. This will be dependent upon whether an offence may have been committed or if the child is at serious risk of significant harm.

If the child has been harmed, has died or been abandoned, child protection procedures will apply and a joint investigation will be conducted with the relevant social work individual.

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Appendix A

Pathway for addressing concerns



Appendix B

Concealed pregnancy risk indicator chart

The indicators below can be used to highlight risk and vulnerability, and to indicate which female may need additional multi-agency assessment and support

Name:		Date of Birth:		
		YES	NO	N/A
1	Lack of pre-natal care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Previous concealed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Irrational perceptions/fears about being pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Lack of suspicion by family/partners/colleagues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Poor parenting experiences as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Effects of early sexual trauma, i.e. Victim of sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Interpersonal problems with partners and/or family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Anticipation of separation from forthcoming baby (including inability to cope or baby will be taken away)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Emotional problems? (Please clarify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Loss of custody of previous child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Presenting with abdominal disorder or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	History of substance misuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14	Mental health difficulties including:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Personality disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Learning disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Previous rejection of a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Previous Social Care involvement re: childcare, including child protection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Moving geographical area/address?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Poor relationships with Health Professionals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Files lost or untraced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	History of not registered with a GP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Not attending health and/or developmental checks with existing child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Thoughts of termination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Lack of information about the father of current pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Family collusion (mother/daughter relationships)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Inability to provide appropriately for child's needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Inability to perceive child's needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix C

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 a female who conceal or deny their pregnancy. Research has also been carried out to explore links between concealed pregnancy and infanticide (killing of a child in the first year of life). Local Safeguarding Children Boards have conducted reviews of cases where concealment or denial of pregnancy has been identified as a factor in the death or serious injury of a child. The issue of concealment and denial of pregnancy, and infanticide/filicide (the killing of a child by a parent) can be evidenced throughout human history and archaeology.

Bromley LSCB: Executive Summary

[SERIOUS CASE REVIEW IN RESPECT OF CHILD A AND B 2011](#)

This SCR relates to two brothers who were brought into the care of the London Borough of Bromley in February 2010 after one of the boys was found to have injuries, said to be caused by his father. There had been substantial contact between the boys' family and various agencies in Bromley, and continuing concerns about neglect of the brothers, over a period of some five years. Historical evidence indicates that the mother was herself adopted at an early age, with assistance sought from her adoptive parents through her adolescence due to her mood swings, poor self-care and an inability to relate to others. By 2003, the mother became pregnant with her first child. The pregnancy was at an advanced stage before she sought any medical advice. Her second child was born some 18 months later, at home, without any ante-natal care or medical assistance. The mother said that she had been unaware of either pregnancy.

Northamptonshire LSCB: Executive Summary

[SERIOUS CASE REVIEW IN RESPECT OF CHILD A October 2008](#)

In April 2008, emergency services were called to a house in Northamptonshire after a teenager had given birth, and were told the baby was dead. It was established the birth had occurred earlier that morning. Later that day the child's mother was arrested in connection with the death of her child and then released on police bail. The child's mother lived with other family members including the dead child's sibling. This child had significant health needs and as a result health and social care professionals had been involved with the family.

TORFAEN LSCB: Executive Summary

[SERIOUS CASE REVIEW REPORT IN RESPECT OF CHILD 1 2011](#)

This Serious Case Review (SCR) concerns a three year old child, who was subject to serious neglect at the hands of his mother and her partner. The evidence of the child's circumstances came to light on 3rd December 2010, when the child was found by Police Officer's at the family home locked in a room. The room was described as being cold, dark and without any lighting or furniture, with the walls covered in human excrement. The child was naked, covered in bruises, and suffering the effects of cold and dehydration.

The child's mother, and her partner, were arrested and charged with neglect. Historical evidence suggests that the mother became pregnant, as a teenager, with her first child. A feature of this and subsequent pregnancies was mother's consideration of placing the child for adoption or terminating the pregnancy. The mother lived an itinerant lifestyle with frequent changes of address following her eviction in 2006. She was homeless during her second pregnancy and subsequent birth of the child concerned although, at the time, her eldest child was already living with his father where he continues to reside. In respect of the child concerned, she had also concealed her pregnancy for 31 weeks, had received no antenatal care, was homeless, and in fear of her ex-partner who had made threats to harm her.

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