Concealed pregnancy guideline (GL809)

Approval

<table>
<thead>
<tr>
<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
<th>Date</th>
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<tbody>
<tr>
<td>Maternity &amp; Children’s Services Clinical Governance Committee</td>
<td>Chair, Maternity Clinical Governance Committee</td>
<td>12th May 2017</td>
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</tbody>
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Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author, job title</th>
<th>Reason</th>
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</thead>
<tbody>
<tr>
<td>1.0</td>
<td>January 2012</td>
<td>Fiona Morris, Safeguarding Midwife</td>
<td>Trust requirement</td>
</tr>
<tr>
<td>2.0</td>
<td>November 2014</td>
<td>Catherine Hiskett, Amanda Shearer</td>
<td>Reviewed</td>
</tr>
<tr>
<td>3.0</td>
<td>Feb 2017</td>
<td>A Shearer, Safeguarding Midwife</td>
<td>Reviewed page 3, 4.1 Antenatal - last sentence added to 2nd paragraph</td>
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This guideline should be read in conjunction with LSCB guidance found here:

- http://berks.proceduresonline.com/chapters/g_concealed_pregnancy.html
1.0 Definition
Pregnancy which is unbooked for antenatal care after 20 weeks (Wessel et al 2002)
Where a female, through fear, ignorance or denial, does not accept or is unaware of
the pregnancy in an appropriate way” (Sadler 2002).

The pregnancy may be **undetected** where both the mother and her carers are
unaware that she is pregnant or it may be a **conscious concealment** where the
mother is aware of her pregnancy and is emotional bonded to the unborn baby but
does not tell anyone. The pregnancy may also be denied, this may be **conscious
denial** where the mother has physical awareness of her pregnancy, but lacks
emotional attachment or **unconscious denial** where the mother is not subjectively
aware of her pregnancy and genuinely does not believe the signs of pregnancy or
even the birth of the baby (e.g. Psychotic delusion).

Concealed Pregnancy is rare; a study in south Wales, published in 2006, found an
incidence rate of 1in 2,500 (Nimal et al 2006).

2.0 Why do women conceal their pregnancies?
There are a variety of reasons but these may include:
• Mental illness e.g. Psychosis, conversion disorder, PND, Substance misuse
• Fear of disapproval of pregnancy
• Conception following rape
• Incestuous paternity
• Extra marital paternity
• Intellectual disability
• Religious / cultural disapproval – shame
• Social services involvement – fear of removal of another child
• Poor social network
• Anti-medical intervention and desire to be “natural
3.0 What are the consequences?

For the baby:
- Stillbirth
- Neonaticide
- Neonatal death
- Infanticide
- Abandonment
- Prematurity
- Low birth weight
- Neonatal morbidity

For the mother:
- Maternal Mortality
- Lack of antenatal care
- Maternal morbidity
- Unassisted delivery
- Poor attachment and bonding
- Guilt
- Legal consequences.

4.0 Responsibilities of the midwife

4.1 Antenatal

When a woman books after 20 weeks the midwife should complete the booking information and all routine screening tests as appropriate and ensure an urgent request for a Consultant clinic appointment is sent. The community midwife should ensure the woman is seen in the hospital clinic within 2 weeks of the initial booking appointment. Consideration should be given to the reason for the concealment and a risk assessment of the reason undertaken. This should include whether a referral is required for assessment of mental health via CPE (Common Point of Entry – see maternal mental health guideline) or Psychiatric Medicine Service.

If child protection issues are identified the midwife should inform the woman of plans to refer to Children’s Social Care in respect of a concealed pregnancy and share the information to ensure access to appropriate services and support. The community midwife will forward a letter to the woman’s GP informing them of the informed of a concealed pregnancy and this should be recorded within her health record by the GP practice as it can indicate a risk of further concealed pregnancies in the future. If a previous concealed pregnancy has been identified, this increases the risk significantly and a safeguarding referral should be sent and the child protection midwife notified.
4.2 Presenting in labour

When a woman presents unbooked in labour the midwife should check the child protection file for a missing person alert for that woman. If an alert relating to that woman is found the relevant children’s services department should be informed as per the alert.

A full clinical risk assessment should be undertaken and the woman should be cared for under consultant care. Bloods should be taken for FBC, Group and Save and Antenatal serology and sent to the lab as an urgent sample.

The relevant children’s social care department for where the woman is living should be informed and if it is out of hours the Emergency Duty Team should be called.

In addition the named midwife, the Poppy team and the woman’s GP and HV should be informed. **The woman and her baby should not be discharged home until a strategy meeting has been held with children’s social care.**

During the postnatal period the woman and her baby should be observed closely for normal attachment. All women who conceal a pregnancy until delivery should be referred (at the point the concealment is identified) for an assessment of their mental health to be conducted prior to them leaving hospital. During CPE office hours please refer to CPE by phone. Outside of CPE office hours please request an assessment via PMS Service at RBH for women who have delivered at RBH and who require an assessment that cannot wait until CPE office hours.

5.0 Contact Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number</th>
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<tr>
<td>Reading MASH</td>
<td>01189 373 641</td>
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<tr>
<td>Wokingham Referral and Assessment</td>
<td>01189 088 002</td>
</tr>
<tr>
<td>Newbury Referral and Assessment</td>
<td>01635 503 190</td>
</tr>
<tr>
<td>Emergency Duty Team</td>
<td>01344 786 543</td>
</tr>
<tr>
<td>Mental Health (CPE)</td>
<td>0300 365 300</td>
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<tr>
<td>PMS (Psychiatric Medicine Service @ RBH)</td>
<td>Ext 6654</td>
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6.0 Concealed Pregnancy Flowcharts

Late booking after 20 weeks

Assess medical and social risk

CP risks identified?

Yes

Refer to children’s social care and the Poppy Team

No

Refer to consultant care for appointment within 2 weeks.

Continue normal antenatal care pathway

Late booking after 20 weeks
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Presents in labour or following delivery

Yes

Inform identified children’s social care

Is there a missing person alert?

No

Inform children’s social care (if out of hours EDT)

Inform GP and HV, ask to update health records

Inform Poppy Team and Named Midwife

Do not discharge until strategy / discharge planning meeting has been held. Consider mental health review

Close observation of attachment in early PN period

Clinical risk assessment
Consultant Care
Full bloods: FBC, Group and Save, Antenatal serology.
References
