Northamptonshire Safeguarding Children Board

Concealed Pregnancies

Practice Guidance

1. Introduction

The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and well being of the foetus (unborn child) and the mother. While concealment and denial, by their very nature, limit the scope of professional help better outcomes can be achieved by coordinating an effective inter-agency approach. This approach begins when a concealment or denial of pregnancy is suspected or in some cases when the fact of the pregnancy (or birth) has been established. This will also apply to future pregnancies where it is known or suspected that a previous pregnancy was concealed. In some cases, pregnancies may be concealed until or after delivery.

This guidance is intended for all professionals who encounter women and girls who conceal the fact that they are pregnant or where there is a known previous concealed or denied pregnancy.

A late booking may indicate a number of different concerns or no concerns at all. This guidance only deals with cases where the pregnancy has been identified to be deliberately concealed.

This guidance must be applied in conjunction with any internal agency procedures and with Northamptonshire Safeguarding Children Board (NSCB) Child Protection Procedures, with particular reference to Pre-birth Toolkit. The guidance does not repeat child protection procedures and therefore constitutes additional, not stand alone, guidance.

This procedure must be read in conjunction with:

- Safeguarding Children from Child Sexual Exploitation
- Sexually Active Young People
- Children Missing from Home and Care Joint Protocol
- Children and Families who go Missing
- Honour based Violence and Forced Marriage Procedure
- The incidence and outcome of concealed pregnancies among hospital deliveries: An 11-year population-based study in South Glamorgan 2006
- A case-study approach from an Irish setting 2006
- Concealed Pregnancy and Child Protection - Scie - Children's Legal Centre 2000

2. Definition

For the purpose of this policy and procedure any reference to **woman or expectant mother** 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; this is the point of viability. However by the very nature of concealment or denial, it may not be possible to establish the exact gestation.

A concealed pregnancy when:

- An expectant mother knows she is pregnant but does not tell any professional
  or
- An expectant mother tells another professional but conceals the fact that she is not accessing antenatal care;
  or
- A pregnant woman tells another person or persons and they conceal the fact from all health agencies.

A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases a woman may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005).

For the purpose of this guidance the phrase concealed pregnancy is used for both denied and concealed pregnancies.

Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery. The birth may be unassisted (no midwife) whereby there might be additional risks to the child and mother's welfare and long-term outcomes.

The history in each case needs to be taken into account and included in any assessment. The question is: **What are the implications for the birth and for the child and family following the birth**?

Unassisted Birth/ Free Birthing

Unassisted or free birth means a woman giving birth without medical or professional help. It is practiced by only a very small group of women. Most women who choose an unassisted birth will have done so after considerable thought and research. It is not a decision that is taken lightly and should be seen as another form of informed choice. Healthcare professionals must refer to the Northamptonshire Multiagency Safeguarding Hub (MASH) if there is a significant risk of harm to the child after it is born and/ or the needs and circumstances of the baby and family meets the threshold for Social care involvement (tier4) as defined by the thresholds and pathways document. Alternatively,

consideration should be given to referring the family to other universal and targeted services and/or undertaking an early help assessment.

3. Reason for Concealment: Messages from Research and Serious Case Review

Research into concealment and denial of pregnancy is relatively recent, in the last 40 years, and this work has attempted to understand the characteristics of women who conceal or deny their pregnancy. Research has also been carried out to explore links between concealed pregnancy and infanticide (killing of a child in the first year of life).

Local Safeguarding Children Boards have conducted reviews of cases where concealment or denial of pregnancy 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.

Recent Serious Case Reviews and child death Inquiries highlighted evidence of considerable ambivalence or rejection of some of those pregnancies with a significant number having little or no ante-natal care. The consistent message from Serious Case reviews is that all professionals must have an understanding of concealed pregnancy in order to provide effective intervention to the unborn baby and the mother. The following are the findings from recent Serious Case Reviews:

- March 2014 - Windsor and Maidenhead - EY and OY
  Issues identified include: insufficient recognition of the risks associated with concealed pregnancy; underestimation of the risks associated with re-unification; and non-compliance with child protection procedures in relation to reporting suspicious injuries. key lessons for practice, including: better coordination of health care for children who are discharged from being looked after; and need for investigation in cases of concealed pregnancy, including the psychological and psychiatric status of the parents.

- January 2014 - Dorset - Family S4
  Serious head injury of a 6 month old baby leading to the baby suffering permanent hemiplegia as a result of the injuries. Key learning points and emerging issues, including: need for greater professional awareness of issues related to concealed pregnancies

- 2010 – Baby A – Bury

Baby found dead by a member of the public. Inquiries indicated that the mother had concealed the pregnancy and that she visited an NHS walk in center before inquiring about termination. Findings included, weaknesses in information sharing between midwifery and GPs; and there is relatively little professional understanding of denial or concealment of pregnancy. Recommendations include: increasing awareness and professional responses to cases of concealed pregnancies amongst professionals and staff training and awareness of diverse cultural and religious groups should be a priority so that practitioners feel confident raising questions about the particular cultural or religious context of service users.

- Torfaen 2011 – Child 1
  Child 1 who was found by police locked in his room, naked, covered in bruises and suffering the effects of cold and dehydration. Concealed pregnancy at 31 weeks, no ante-natal care accessed, 3 children previously removed and adopted. Evasion of professionals and professionals having no access to the child for 7 weeks.

- Child C Lewisham 2009
  Death of a newborn. Mother concealed the newborn's pregnancy and previous pregnancies. Recommendations for joint working and concealed pregnancy protocol made.

- Hertfordshire 2009 – Child R
  Ms A concealed or denied her pregnancy with R for a long period and concerns were raised about Ms A's parenting ability including forgetting to feed R which led to weight loss and her decision to live with a known violent offender. Ms A has learning disabilities and had experienced sexual abuse as a child. The maternal uncle living in the same house was using and selling drugs. Review identifies over-optimism and 'start again syndrome' by professionals as well as a failure to consider R's older sibling. Recommendations include the introduction of guidance concerning concealed/denied pregnancy and guidance for suspected 'Non Organic Failure to Thrive'

- Northamptonshire Child A 2008
  Review into the death in April 2008 of Child A, a newborn baby born to a teenage mother who had concealed the pregnancy. Child A's older sibling Child B, who lived with the mother, had significant health needs and so the family was known to health and social care services. Issues included: teenage pregnancy; concealed pregnancy; and parenting a child with health needs. Recommendations include: implementation of an Integrated Teenage Pregnancy Pathway, including protocol

for failed appointments and terminations; Midwifery services to undertake home visits to all post natal women; use of the Common Assessment Framework in cases of teenage pregnancy; and multi-agency staff training and processes.

- North-east Lincolnshire 2008
  Review into the death of a newborn baby, Baby E. The cause of death has not been established. The mother had denied and concealed the pregnancy and two previous pregnancies. The mother and four surviving children were not known to children's social care. Recommendations include national research to determine the impact of concealed pregnancies on safeguarding children, specific policy and guidance on concealed pregnancy, and schools to seek external help for unauthorised absences of children.

- Suffolk child D
  Review following the death of a newborn baby in October 2007. He was born in secret following a concealed pregnancy. D's mother was 15 and his father was 17 when D was born. Recommendations are around working with sexually active children under the age of 18 and following up periods of unauthorised absence from school.

A summary of thirty-five major child death inquiries (Reder P, 1993) highlighted evidence of considerable ambivalence or rejection of some of those pregnancies and a significant number with little or no antenatal care. A follow-up study (Reder P. D., 1999) also identified a small sub-group of fatality cases where mothers did not acknowledge that they were pregnant and failed to present for any antenatal care and the babies were born in secret.

Several studies (Earl, 2000); (Friedman S. M., 2005); (Vallone, 2003) highlight a well-established link between neonaticide - killing of a child by a parent in the first 24 hours following birth - and concealed pregnancy. A review of 40 Serious Case Reviews (DoH, 2002) identified one death was significant to concealment of pregnancy.

There are 4 studies that at some of the psychological dimensions of concealed and denied pregnancy (Brezinkha, 1994); (Earl, 2000) (Moyer, 2006) (Spielvogel, 1995). In some cases a woman may be unaware that she is pregnant until late in the pregnancy due to a learning disability. Concealment may occur as a result of stigma, shame or fear as felt by the woman because the pregnancy is the result of incest, sexual abuse, rape or as part of a violent relationship. Moyer notes that the majority of women who deny pregnancy do not have a mental health assessment.

There are links between denial of pregnancy and dissociative states brought about by trauma or loss; or denial stems from a woman misusing drugs or alcohol which can harm the foetus or because of mental illness, such as schizophrenia.

A number of studies have attempted to identify the frequency of concealment or denial of pregnancy (Nirmal, 2006); (Wessel, 2002). They suggest concealment might occur in about 1:2500 cases (0.04%). A study by (Friedman S. H., 2007) showed a higher proportion with 0.26% of all pregnancies in their sample (approx 31000) to be concealed or denied. The characteristics of those in this study showed that 50% of those concealing the pregnancy and 59% of those denying the pregnancy were aged between 18 and 29 years. Only 40% of those concealing and 23% of those in denial of their pregnancy were under 18 years of age.

A recent study in France into the rate of neonaticide by looking back at judicial data (court cases and inquests) concluded that the rate was 2.1 per 100,000 births, a much higher rate that the official mortality statistics suggested. All of the pregnancies identified in the study were concealed but none were completely denied by the woman (no awareness of being pregnant). The characteristics of the women in the study were explored and over half of them lived with the child's father, and 13 of the 17 women identified were classed as professionally active with a status identical to that of the general population. The authors concluded that neonaticide appeared as a solution to an unwanted pregnancy that risked a family scandal or loss of a partner or lifestyle. (Tursz and Cook, 2010).

The majority of religious faiths traditionally expect pregnancy to follow after marriage. Dependent upon the culture and religious observance, a pregnancy outside of marriage may have serious consequences for the women involved. This can create a significant pressure on a woman to seek to conceal a pregnancy or for the psychological conditions to be present where a pregnancy is denied. In some local and national cases collusion between family or partners has occurred to facilitate and encourage concealment of the pregnancy from those outside of the family or wider culture/community. Some pregnant women, or their partners, who abuse drugs and /or alcohol may actively avoid seeking medical help during pregnancy for fear that the consequences of increased attention from statutory agencies can result in the removal of their child.

4. Implications of Concealed Pregnancies

The implications of concealment and denial of pregnancy are wide-ranging. Concealment and denial can lead to a fatal outcome, regardless of the mother’s intention.

Lack of antenatal care can mean that potential risks to mother and child may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or fetal abnormalities detected. It may also lead to inappropriate medical advice being given; such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy.

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. A midwife should be present at birth, whether in hospital or if giving birth at home.

Good practice in Antenatal care

- Midwives and GP's should care for woman with an uncomplicated pregnancy, providing continuous care throughout. Obstetricians and specialist teams should be brought in where necessary.
- In the first contact with a health professional a woman should be given information on folic acid supplements; food hygiene and avoiding food-acquired infections; lifestyle choices such as smoking cessation or drug use; and the risks and benefits of antenatal screening.
- The booking appointment with a midwife ideally should be around 10 weeks. This appointment should help the woman plan the pregnancy, offer some initial tests and take measurements to help determine any specific risks for the pregnancy. The woman should be given advice on nutritional supplements and benefits.
- Give information that is easily understood by all women, including those with additional needs, learning difficulties or where English is not their first language. Ensure the information is clear, consistent and backed up by current evidence.
- Remember to give a woman enough time to make decisions and respect her decisions even if they are contrary to your own views.
- Woman should feel able to disclose problems or discuss sensitive issues with you. Be alert to the symptoms and signs of domestic violence.

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

An implication of concealed or denied pregnancy could be a lack of willingness or ability to consider the baby's health needs, or lack of emotional bond with the child following birth. It may indicate that the mother has immature coping styles or is simply unprepared for the challenges of looking after a new baby. In a case of a denied pregnancy the effects of going into labour and giving birth can be traumatic.

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 may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community; or because revealing the identity of the child's father may have consequences for the parents and the child.

5. When Suspicion About Concealed Pregnancy Arise

This section outlines actions to be taken when a concealed or denied pregnancy is suspected. If a pregnancy is suspected of being concealed or denied, the woman should be strongly encouraged to visit her Midwife or GP to access ante-natal care.

Professionals must balance the need to conserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. Where any professional has concerns about concealment or denial of pregnancy then they should contact other agencies known to have involvement with the woman so that a fuller assessment of the available information and observations can be made.

Where there is a strong suspicion there is a concealed or denied pregnancy then it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the unborn child will override the mother's right to confidentiality. A referral should be made to the Northamptonshire MASH about the unborn child. If the woman is aged less than 18 years then consideration will be given to whether she is a child in need. If she is less than 16 years then a criminal offence may have been committed and needs to be investigated.

The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the unborn child or newborn baby. The reasons will not be known until there has been an assessment. If there is a denial of pregnancy then consideration must be given at the earliest opportunity to a referral for mental health services. Advice can be sought from the designated or named professional or from the Northamptonshire MASH.

6. Legal considerations about Concealment and Denial of Pregnancy

United Kingdom law does not legislate for the rights of unborn children and therefore a fetus is not a legal entity and has no separate rights from its mother. This should not prevent plans for the protection of the child being made and put into place to safeguard the baby from harm both during pregnancy and after the birth.

In the case of F (in utero) 1988 the Court of Appeal was asked to make a fetus a ward of court by a Local Authority concerned for the welfare of the child. The pregnant woman's previous child was in foster care and she was described as having a mental disturbance, nomadic lifestyle and occasional drug use. The Court was entirely opposed to the proposed action, with one judge stating that the purpose was to control the woman's actions to protect the unborn child to the extent that she would be ordered to stop smoking, imbibing alcohol and refraining from all hazardous activity (Royal College of Obstetrics and Gynaecology, 2006).

In certain instances legal action may be available to protect the health of a pregnant woman, and therefore the unborn child, where there is a concern about the ability to make an informed decision about proposed medical treatment, including obstetric treatment. The Mental Capacity Act 2005 states that person must be assumed to have capacity unless it is proven that she does not. A person is not to be treated as unable to make a decision because they make an unwise decision. It may be that a pregnant woman denying her pregnancy is suffering from a mental illness and this is considered an impairment of mind or brain, as stated in the act, but in most cases of concealed and denied pregnancy this is unlikely to be the case.

There are no legal means for a Local Authority to assume parental responsibility over unborn baby. Where the mother is a child and subject to a legal order, this does not confer any rights over her unborn child or give the local authority any power to override the wishes of a pregnant young woman In relation to medical help.

7. When a Concealed or Denied Pregnancy is revealed

This section outlines actions to be taken when a concealed or denied pregnancy is revealed. Midwifery services will be the primary agency involved with a woman after the concealment is revealed, late in pregnancy or at the time of birth. However it could be one of many agencies or individuals that a woman discloses to or in whose presence the labour commences. It is vital that all information about the concealment or denial is recorded and shared with relevant agencies to ensure the significance is not lost and risks can be fully assessed and managed.

When a pregnancy is revealed the key question is 'why has this pregnancy been denied or concealed?' The circumstances in each case need to be explored fully with the woman and appropriate support and guidance given to her. Where possible a full pre-birth assessment should be undertaken by Children's Social Care and if evidence of potential significant harm has been identified in relation to the unborn baby an initial child protection (pre-birth) case

conference convened to manage any concerns for the safety of the unborn child. A referral to mental health services should also be considered by health professionals

When a pregnancy is concealed or denied to birth then a referral must be made by the health professional to the Northamptonshire MASH and a mental health referral considered.

8. Educational Settings

In many instances staff in educational settings may be the professionals who know a young person best. There are several signs to look out for that may give rise to suspicion of concealed pregnancy:

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

Staff working in educational settings should try to encourage the young person to discuss her situation, through normal pastoral support systems, as they would any other sensitive problem. Every effort should be made by the professional suspecting a pregnancy to encourage the young person to obtain medical advice. However where they still face total denial or non-engagement further action should be taken. It may be appropriate to involve the assistance of the Designated Person for Child Protection in addressing these concerns.

Consideration should be given to the balance of need to preserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained. Where there are concerns of possible Child Sexual Exploitation, a risk assessment and a referral to the Northamptonshire MASH must be completed (See Safeguarding Children from Sexual Exploitation Procedure & Toolkit).

Education staff may often feel the matter can be resolved through discussion with the (not if consent is not given to tell the parents about the pregnancy from the young person) parent of the young person However this will need to be a matter of professional judgement and will be clearly depend on individual circumstances including relationships with parents. It may be felt that the young person will not admit to her pregnancy because she has genuine fear about her parent's reaction, or there may be other aspects about the home

circumstances that give rise to concern. If this is the case then a referral to the Northamptonshire MASH should be made without speaking to the parent's first.

If education staff do engage with parents they need to bear in mind the possibility of parent's collusion with concealment. Whatever action is taken, or involving another agency, the young person should be appropriately informed, unless there is a genuine concern that in so doing she may attempt to harm herself or the unborn baby.

As with any referral to MASH, (cannot inform unless consent from young person) and young person should where possible be informed, unless in doing so there could be significant concern for her welfare or that of her unborn child.

9. Health Professionals

Clinical Commissioning Groups are responsible for commissioning of acute and community health services in hospital and community settings. The local commissioners of health services are responsible for ensuring all its providers fulfil their statutory responsibilities for safeguarding children.

The health professionals whom may be involved include:

- Health Visitors
- School nurses
- General Practitioners and Practice nurses
- Midwifes and Obstetricians/Gynaecologists
- Mental Health Nurses
- Drug and Alcohol workers
- Learning Disability workers
- Psychologists and Psychiatrists

(This is not an exhaustive list)

If a health professional suspects or identifies a concealed or denied pregnancy they must refer to the Northamptonshire MASH and to inform all other health professionals that need to be involved in her care.

All health professionals should give consideration to her indivdual need to make or initiate a referral for a mental health assessment at any stage of concern regarding a suspected (or proven) concealed or denied pregnancy. Accident and Emergency staff or those in Radiology departments need to routinely ask women of child bearing age whether they might be pregnant.

Health professionals who provide help and support to promote children's or women's health and development should be aware of the risk indicators and how to act on their concerns if they believe a woman may be concealing or denying a pregnancy.

10. Midwives & Midwifery Services

If an appointment is for antenatal care is made late (beyond 24 weeks) the reason for this must be explored. Midwives and Obstetricians should consider whether a mental health referral is indicated. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby then a referral to the Northamptonshire MASH must be made. The woman should be informed that the referral has been made, the only exception being if there are significant concerns for her safety or that of the unborn child.

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 the Northamptonshire MASH. If this is in an evening, weekend or over a public holiday then the Emergency Duty team must be informed.

If the baby has been harmed in any way or there is a suspicion of harm, or the child is abandoned by the mother, then the Police must be informed immediately and a referral made to the Northamptonshire MASH.

Midwives should ensure information regarding the concealed pregnancy is placed on the child's, as well as the mother's health records. Following an unassisted delivery or a concealed/denied pregnancy midwives need to be alert to the level of engagement shown by the mother, and her partner/extended family if observed, and of receptiveness to future contact with health professionals. In addition midwives must be observant of the level of attachment behaviour demonstrated in the early postpartum period.

In cases where there has been concealment and denial of pregnancy, especially where there has been unassisted delivery considera referral for a full mental health assessment. In addition the baby should not be discharged until a multi-agency strategy meeting has been held and relevant assessments undertaken. A discharge summary from maternity services to primary care must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks).

11. Children's Social Care

Where the expectant mother is under the age of 18 initial approaches should be made confidentially to the young woman to discuss concerns regarding the potential concealed

pregnancy and unborn child. She should be provided with the opportunity to satisfy social workers that she is not pregnant, by undertaking appropriate medical examination or investigation, or to make realistic plans for the baby, including informing her parents. The Northamptonshire MASH may receive a referral from any source which suggests a pregnancy is being concealed or denied. In all cases a multi-agency strategy meeting should be convened, involving all the relevant agenciesto assess the information and formulate a plan. A pre-birth assessment will be undertaken.

In the event that the young woman refuses to engage in constructive discussion, and where parental involvement is considered appropriate to address risk, the parent/main carer should be informed and plans made wherever possible to ensure the unborn baby's welfare. Potential risks to the unborn child or to the health of the young woman would outweigh the young woman's right to confidentiality, if there was significant evidence that she was pregnant. There may be significant reasons why a young woman may be concealing a pregnancy from her family and a social worker may need to consider speaking to her without her parent's knowledge in the first instance.

If the young woman refuses to engage in constructive discussion then the social worker will need to inform her parent/s or carers and continue to assess the situation with a focus on the needs /welfare of the unborn baby as well as those of the young woman, who should be considered a child in need. In this situation professionals will have very clear reasons for suspecting pregnancy in the face of continuing denial or concealment and such a situation will require very sensitive handling.

Regardless of the age of the woman where there are additional concerns (to the suspected concealed or denied pregnancy) such as a lack of engagement, possibility of sexual abuse, or substance misuse; then a child protection investigation/Enquiry will be undertaken. The only outcome will be to convene a pre-birth child protection conference. Where a woman under age 18 is suspected of being pregnant then professionals must not lose sight of the fact that she is also a child in need.

If a woman has arrived at hospital either in labour (when a pregnancy has been concealed or denied) or following an unassisted birth an initial assessment must be started and a multi-agency strategy meeting convened. In all cases the need to convene a Child Protection Conference must be considered.

Where a baby has been harmed, has died or has been abandoned then a Section 47 investigation must be completed in collaboration with the Police.

Any referral received by the Emergency Duty Team in relation to a baby born following a concealed or denied pregnancy, or where a mother and baby have attended hospital

following an unassisted delivery, then steps may need to be taken to prevent the baby being discharged from hospital until a multi-agency strategy meeting has been held and a plan for discharge agreed. This would ordinarily be done by voluntary agreement with the woman, although clearly circumstances may arise when it may be appropriate to seek an Emergency Protection Order. Alternatively the assistance of the Police may be sought to prevent the child from being removed from the hospital.

In undertaking an assessment the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child. These factors along with the other elements of the Assessment Framework will key in determining risk.

Accessing psychological services in concealment and denial of pregnancy may be appropriate and consideration should be given to referring a woman for psychological assessment. There could be a number of issues for the woman which would benefit from psychological intervention. A psychiatric assessment might be required in some circumstances, such as where it is thought she poses a risk to herself or others or in cases where a pregnancy is denied.

The pathway for psychological or psychiatric assessment, either before or after pregnancy is the same. A referral should be made using the single point of entry to mental health services and the referral letter copied to the woman's GP. The referral should make clear any issues of concern for the woman's mental health and issues of capacity.

12. The Police

The Police (Public Protection Unit) will be notified of any child protection concerns received by children's social care where concealment or denial of pregnancy is an issue. A police representative will be invited to attend a multi-agency strategy meeting and consider the circumstances and to decide whether a joint CP investigation should be carried out.

Factors to consider will be the age of the woman whom is suspected or known to be pregnant, and the circumstances in which she is living to consider whether she is a victim or potential victim of criminal offences. In all cases where a child has been harmed, been abandoned or died, it will be incumbent on police and social care to work together to investigate the circumstances. Where it is suspected that neonaticide or infanticide has occurred then the Police will be the primary investigating agency.

13. Other NSCB member agencies (including the voluntary sector)

All professionals or volunteers in statutory or voluntary agencies who provide services to women of child bearing age should be aware of the issue of concealed or denied pregnancy and follow this procedure when a suspicion arises.

All referrals will be made to the Northamptonshire MASH initially as a referral on an unborn child. Where the expectant mother is under 18 years of age she will be considered as a child in need and assessed accordingly.