

Clinical Guideline for the Management of: Concealed Pregnancies Denied or Undiagnosed Pregnancies Late Pregnancy Bookings Unassisted (Free) Births

Key Points:

- All bookings/presentations after 20 weeks' gestation, with no evidence of previous antenatal care, must be referred to Children's Social Care (CSC) for a multi-disciplinary team (MDT) approach.
- When booking a transfer of care, upload evidence of previous care to the media files.
- Contact the previous hospital to obtain a handover of medical and social care when arranging a transfer of care.
- Apply professional curiosity to gather information and carry out a thorough risk assessment.
- The threshold for identifying a concealed pregnancy does not need to wait until 20 weeks' gestation if there is reason to believe the pregnancy is already being concealed.
- An interpreter must be provided for women whose first language is not English or who have a sensory impairment.

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Abbreviations

ED	Emergency Department / Accident & Emergency
DAU	Day Assessment Unit / Maternity Assessment Unit
EPU	Early Pregnancy Unit
IDU	Intrauterine Death
CP-IS	Child Protection – Information sharing
NOP	Notification of Pregnancy
FHFT	Frimley Health Foundation Trust
ASAP	As soon as possible
GP	General Practitioner
USS	Ultrasound Scan
EPIC	Electronic Patient Records
ISF	Information sharing Form
NIPE	Newborn Infant Physical Examination
AN	Antenatal
NNU	Neonatal unit
HV	Health Visitor
CSC	Children's Social Care
NHS	National Health Service
SIDS	Sudden Infant Death Syndrome
ICON	Infant crying is normal, Comforting methods can help, It's OK to walk away, Never, ever shake a baby.

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1. Purpose of this Guideline

- 1.1. This guideline is intended for hospital staff who may encounter women concealing their pregnancy or when there is a professional suspicion that a pregnancy is being concealed or denied. It also provides guidance for cases where a woman books maternity care late. The purpose of this guideline is to help minimise the risks associated with concealed or denied pregnancies.
- 1.2. This guidance should be read in conjunction with Children’s Social Care guidance within the woman’s local authority (council).
- 1.3. When a pregnancy is concealed, whether the baby is born alive or an intrauterine death (IUD) is diagnosed, the midwife providing care must conduct a comprehensive assessment. This should include evaluation of social circumstances such as housing, finances, family dynamics, learning needs, mental health, and any domestic abuse concerns, along with any necessary onward referrals. The midwife should also explore and document potential reasons for the pregnancy concealment, parenting preparation, available support, safe sleeping arrangements, and whether the woman’s wishes to parent the child.

2. The Guidance

2.1. Background

The 2025 UK report *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* (MBRRACE) *Saving Lives, Improving Mothers’ Care*, found that over two-thirds of women who died did not receive the nationally recommended level of antenatal care. Access to antenatal services continues to be a significant challenge, and ensuring equitable access for all groups must remain a priority in service planning. Among the women who died, two-thirds were affected by medical and mental health conditions.

The concealment of pregnancy poses a significant challenge for professionals tasked with safeguarding the welfare and wellbeing of both the unborn child and the mother. Research by Higuieras et al 2024, concluded that better outcomes are achieved through a coordinated multi-agency approach once the pregnancy is identified. This approach is also important for any future pregnancies following a previous concealed pregnancy. In some cases, pregnancies may remain concealed until labour or after delivery, requiring heightened attention to the baby's safety and the mother's wellbeing.

Definitions (All three necessitate a referral to Children's Social Care):

2.2. Concealed Pregnancy

A **concealed** pregnancy occurs when a woman is aware of their pregnancy but intentionally hides this information from healthcare professionals and, at times, from family or friends.

2.3. Denied Pregnancy

A **denied** pregnancy occurs when a woman is unaware of, or unable to accept, that they are pregnant. Physical changes may be absent or misinterpreted; although they may intellectually acknowledge the pregnancy, they continue to think, feel, and behave as if they are not pregnant. In some cases, denial may be linked to mental illness, substance misuse, or a history of child loss.

2.4 Undiagnosed Pregnancy

An **undiagnosed** pregnancy occurs when a woman is unaware of their pregnancy until labour begins or the baby is born.

2.5 Reasons and implications of a Concealed Pregnancy

The reason for the concealment is key to assessing the risk to both mother and child and can only be determined after a full risk assessment.

Women may conceal their pregnancies for a variety of reasons, including: (adopted from Greater Manchester and Eastern Cheshire Strategic Clinical Networks (2023))

- Mental illness.
- Substance misuse.
- Domestic abuse.
- Fear of disapproval of pregnancy.
- Conception following rape.
- Incestuous paternity.
- Learning disability.
- Religious / cultural disapproval or shame.
- Children's Social Care involvement – fear of removal of the child.
- Poor social network.
- Fear of financial implications if not entitled to NHS care

- Anti-medical intervention and desire to be 'natural'
- Adverse Childhood Experiences

The consequences of concealing or denying a pregnancy are far-reaching. Babies born following concealment can be highly vulnerable and may experience poor outcomes, sometimes fatal, regardless of the pregnant woman's intentions. (Chase et al 2021)

Murphy-Tinge & Lalor (2019) proved that lack of antenatal care can result in undetected risks to both mother and child. The baby's health and development during pregnancy and labour may go unmonitored, and fetal abnormalities may remain unidentified.

Additionally, it can lead to inappropriate medical advice, such as the prescription of potentially harmful medications by healthcare providers unaware of the pregnancy.

Research by Delong et al 2022 highlighted that an unassisted delivery can pose serious risks to both mother and baby due to potential complications during labour and childbirth.

Postnatal risks highlighted by Stenton & Cohen (2020) may include:

- An unwillingness or inability to address the baby's health needs
- Lack of emotional bonding with the child after birth
- Difficulty adapting to parenthood, which may lead to neglect or abandonment
- Infanticide, defined as the intentional killing of children under 12 months of age

The circumstances surrounding the concealment or denial of pregnancy should be explored on a case-by-case basis. Such situations may raise serious safeguarding concerns for both mothers and babies.

Information must be shared with relevant agencies to ensure its importance is recognised and future risks can be properly assessed and managed.

3. Responsibilities

The type of care a woman requires during her pregnancy depends on where she first seeks care. It is essential that staff apply professional curiosity to gather comprehensive information, ensuring thorough documentation and appropriate referrals to other services.

3.1 ED/DAU/Triage/MAC/EPU:

Responsibilities of ED/DAU/MAC/Triage/EPU staff, when a pregnant woman attends and is not booked at Frimley Health.

The staff member must follow internal procedures for checking missing person alerts and CP-IS. If uncertain, they should consult senior members of the department. If an alert is identified for the mother/unborn, the appropriate Children's Social Care should be notified in accordance with the alert.

- Ask the woman if they have booked their pregnancy care and which hospital they are registered with.
- If not booked and under 20 weeks gestation:
 - Ask which hospital they plan to book with.

- If they wish to book elsewhere, support and advise them to complete the Notification of Pregnancy (NOP) for that hospital. Staff member to then email the Maternity Safeguarding Midwife so they can notify the other hospital.
 - If they wish to book with Frimley Health Foundation Trust (FHFT), support and advise the woman to complete the online NOP. Staff member to email the Maternity Safeguarding Midwife so the Community Midwifery Team can be informed.
- If not booked and 20 weeks or more:
 - Midwifery staff, arrange an urgent booking. ED/EPU liaise with the labour ward coordinator to arrange for a midwife to complete the urgent booking.
 - The booking midwife should then follow up accordingly.
- If booked elsewhere:
 - Request evidence of care from the other hospital and upload relevant documentation to the media files.
 - Contact the booking hospital to inform them of the recent attendance and confirm there are no safeguarding concerns.
 - If no evidence or confirmation is provided, treat as a concealed pregnancy and complete an antenatal booking. (Note: the threshold for concealed pregnancy does not have to be 20 weeks if there is reason to believe the pregnancy is already being concealed.)

3.2 Antenatal Booking for late presentation 14+0 – 19+6 weeks gestation:

Booking appointment must be completed as soon as possible after notification of the pregnancy.

- The Midwife must follow internal procedures for checking missing person alerts and CP-IS. If uncertain, they should consult senior members of the department. If an alert is identified for the mother/unborn, the appropriate Children's Social Care should be notified in accordance with the alert.
- An interpreter must be provided for mothers whose first language is not English or who have a sensory impairment.
- If the woman is from overseas, inform the overseas team. Encourage and support them to register with their local GP (if not already registered) and arrange a medical examination.
- The reason for late presentation should be explored, assessed, and thoroughly documented. Use the Smart text proforma for late presentations (See appendix 1).
- If it is determined that the woman was aware of the pregnancy but delayed accessing care, and an exploration of the circumstances raises concerns for the welfare of the unborn baby, a referral to Children's Services must be made. The mother should be informed of the referral, except where there are significant concerns for their safety or that of the unborn child. (Note: the threshold for concealed pregnancy does not require the pregnancy to be 20 weeks if there is reason to believe it is already being concealed.)

- Consider referring to Adult Social Care if there are concerns that the woman may be at risk of abuse.
- Complete the antenatal booking and arrange scans and obstetric appointments according to the criteria for scans and consultant-led care.
- The antenatal booking administration team is responsible for ensuring urgent dating and anomaly ultrasounds are scheduled if needed.
- Conduct a risk assessment for any current safeguarding concerns, using the smart text as a tool (Appendix 1)
- If no current or significant historical safeguarding concerns are identified, complete the Safeguarding Assessment Form on EPIC as “Information Sharing Only,” with a plan to monitor further engagement.
- Share the Information Sharing Form with the Health Visitor and GP, along with the antenatal booking letter.
- If concerns arise regarding non-engagement following a late booking, refer to Children’s Social Care.

3.3 Antenatal Booking for late presentation 20+0 weeks onwards:

Booking Appointment must be completed as soon as possible after notification of the pregnancy.

- The Midwife must follow internal procedures for checking missing person alerts and CP-IS. If uncertain, they should consult senior members of the department. If an alert is identified for the mother/unborn, the appropriate Children’s Social Care should be notified in accordance with the alert.
- An interpreter must be provided for mothers whose first language is not English or who have a sensory impairment.
- If the woman is from overseas, inform the overseas team. Encourage and support them to register with their local GP (if not already registered) and arrange a medical examination.
- The reason for late presentation must be explored, assessed, and fully documented. Use the Smart text proforma for late presentation (See Appendix 1).
- Complete the antenatal booking and arrange scans and obstetric appointments as per criteria for scans and consultant-led care.
- The antenatal booking administration team is responsible for ensuring that dating, anomaly, or growth ultrasounds are scheduled if required.
- A referral to Children’s Social Care must be made due to delayed engagement in pregnancy care and presentation after 20 weeks, which may indicate a concealed pregnancy. Other circumstances of concern must also be explored and included in the

referral. The woman should be informed that the referral has been made unless there are significant safety concerns for them or the unborn child.

- Consider referring to Adult Social Care if there are concerns that the woman may be at risk of abuse.
- Complete the Safeguarding Assessment form on EPIC as a 'Safeguarding Concern' and include all relevant information from the Smart text in the Children's Social Care referral.
- Share the Children's Social Care referral with the Health Visitor (HV) and GP along with the antenatal booking letter.
- The community midwife should follow up on the referral with Children's Social Care (CSC).
- Discuss equipment needs and refer to local services for baby equipment if required.
- If the case is open to Children's Social Care, the community midwife should keep the social worker informed about engagement and update the HV and GP on CSC involvement.
- If the case is closed to Children's Social Care, re-refer if new concerns arise, and update the HV and GP on the closure.

3.4 Presenting in labour/recently delivered:

When a woman presents unbooked in labour or has recently delivered (e.g., a birth before arrival (BBA) or brought in by ambulance immediately after birth),

The Midwife must follow internal procedures for checking missing person alerts and CP-IS. If uncertain, they should consult senior members of the department. If an alert is identified for the mother/unborn, the appropriate Children's Social Care should be notified in accordance with the alert.

The woman should be managed under consultant-led care.

A full booking must be completed, with an interpreter provided if necessary. If the woman is from overseas, inform the overseas team and

An InPhase must be completed.

All antenatal screening blood tests should be offered and sent to the laboratory as urgent samples. Screening for infectious diseases must be arranged urgently by telephone with the laboratory or, if out of hours, through the on-call microbiologist. Note that syphilis serology results may not be available until the next working day.

Consider consenting to a urine toxicology test if concerns around substance misuse are identified.

If routine screening tests in pregnancy, cannot be offered during labour, the attending midwife should ensure the mother is given the opportunity to undergo

screening as soon as possible during the postnatal period and make appropriate arrangements for this.

If screening is conducted on any inpatient ward, the attending midwife should email the Antenatal Screening team with the mothers' details to ensure proper tracking and follow-up:

- Frimley site: fph-tr.antenatalscreening@nhs.net
- Wexham site: fph-tr.AntenatalandNewBorn@nhs.net

Notify the labour ward coordinator, safeguarding midwives (during working hours), and senior midwives (out of hours) about the mother's arrival.

Inform the paediatric team and neonatal unit (NNU) if the woman presents in labour, in case the baby requires additional care after birth.

The reason for late presentation must be explored, assessed, and thoroughly documented. Use the Smart text proforma for late presentation (See Appendix 1)

Discuss making a referral to Children's Social Care due to delayed engagement with pregnancy care and presentation in labour or after birth, which may indicate a concealed pregnancy.

Address any other potential safeguarding concerns identified.

Contact the Children's Services department based on the local authority where the family resides to inform them, followed by a referral. If out of hours, contact the Emergency Duty Team.

Complete the Safeguarding Assessment form on EPIC, categorising it as a 'Safeguarding Concern,' and submit a follow-up referral to Children's Social Care, ensuring all relevant information from the Smart text is included.

Share the Children's Social Care referral and booking letter with the community midwife team, who will then distribute these to the relevant GP and Health Visitor (HV) teams.

Refer the baby to a paediatrician for the Newborn Infant Physical Examination (NIPE) and care planning. Neonatal observations should be discussed and determined by the paediatric team.

Discuss the purchase of equipment and refer to local services for baby equipment if needed.

Complete parenting observations, minimum of one per shift, and document these on the parenting capacity flowsheets. Ensuring a comprehensive record of parenting observations is maintained.

Await feedback from Children's Social Care before beginning discharge planning. The baby must not be discharged without a formal discharge planning meeting.

3.5 Unassisted birth/free birthing

If a woman informs us that she is pregnant but intends to have an unassisted (free) birth or declines care, please discuss this with the Maternity Safeguarding team for further support and guidance.

If a woman presents in labour or following birth stating she planned an unassisted (free) birth, verify whether she informed any other healthcare providers of her intentions. If there is no evidence of this, the pregnancy should be considered concealed, and appropriate Children's Social Care referrals must be made.

3.6 Postnatal care/plan:

Families who present with a concealed pregnancy and are referred to Children's Social Care must receive enhanced postnatal care to monitor attachment, bonding, and parenting ability. The frequency and nature of enhanced care depend on medical and social needs, as well as input from other professionals. The community midwife is responsible for arranging these appointments, with a minimum of one per week.

The first postnatal visit must be conducted at home and, if necessary, jointly with another service provider.

Subsequent postnatal contacts may take place at the community hub unless there are social or financial barriers preventing the mother and/or baby from attending.

A risk assessment of the home environment must be completed, including a safety check of the baby's sleep environment.

Observations of the parents' interactions with the baby should be documented. Discussions about SIDS and the ICON programme must be held with all adults living in the home or those with parental responsibility.

The final postnatal contact should include a joint handover to the Health Visitor, ideally around day 28.

If the family remains open to Children's Social Care, the community midwife should notify them of the discharge to Health Visitor and GP care.

If the family do not engage with postnatal care, the DNA/Child not brought process must be followed and Children's Social Care informed.

4. Implementation Plan

This guideline will be implemented as follows:

- Guidelines are approved locally at Obstetric Clinical Governance Group, the minutes of which are available on the maternity shared drive and Trust intranet.
- The guideline will be placed on the Trust intranet for viewing by any member of staff.

5. Monitoring compliance

This guideline will be subject to three yearly audits. The audit midwife is responsible for coordinating the audit. Results presented to the department clinical audit meeting. Action plans will be monitored at the department clinical audit meeting.

6. References

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APPENDIX 1

SMART Text for all bookings after 14 weeks gestation who do not have evidence of care with another hospital

If 14+0-19+6 complete form, risk assess if Children's Social Care (CSC) referral required

If 20 weeks or more – complete form and always refer to CSC

(Gestation based on when they made contact for care – not the day of booking)

Abbreviations:

FOB = Father of baby/unborn / MH = Mental Health / DA = Domestic Abuse

Question	Answer	Details
Gestation at first contact		Reason for late booking:
Maternal Age		N/A
Relationship status		N/A
Partner Age		N/A
Maternal Ethnicity		N/A
Is Partner FOB	Yes/No	No: Who is FOB? Name, DOB and address:
Partner/FOB any other children	Yes/No	Yes: Names, DOB and address:
Any other household members	Yes/No	Yes: Names, DOB:
Arrived in country within last 12 months	Yes/No	Yes: Reason came and how travelled:
Does the family speak & Understand English	Yes/No	No: Translator required at every appointment
Mother MH concerns	Yes/No	Yes:
Partner/FOB MH concerns	Yes/No	Yes:
Referred for MH support	Yes/No	Yes:
Mother Learning Difficulties or Disabilities	Yes/No	Yes:
Partner/FOB Learning Difficulties or Disabilities	Yes/No	Yes:
Mother current or previous substance misuse	Yes/No	Yes:
Urine toxicology required	Yes/No	Yes: declined/consented
Partner/FOB current or previous substance misuse	Yes/No	Yes:
Referred for drug and alcohol support	Yes/No	No:

Mother current or previous social care	Yes/No	Yes:
Partner/FOB current or previous social care	Yes/No	Yes:
Siblings to unborn current or previous social care	Yes/No	Yes:
Siblings to unborn placed into care	Yes/No	Yes:
Mother current or previous DA	Yes/No Victim/Perpetrator	Yes:
Partner/FOB current or previous DA	Yes/No Victim/Perpetrator	Yes:
Referred for DA support	Yes/No	Yes:
Mother/FOB/Partner or any household members previous or current police involvement	Yes/No	Yes:
Local support Network	Yes/No	Yes:
Referred to Children's Social Care	Yes/No	Reasons: If referred – attached copy of this form.
Any other comments or concerns eg: housing/finances	Yes/No	Yes:

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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Dec 2025	Prudence Chikwanha, Charlenne Thompson	Final	New guideline. Ratified at Cross Site Obstetrics Clinical Governance Meeting, 16.12.2025

Related Documents

Document Type	Document Name
Trust Policy	Safeguarding Children Policy
Trust Policy	Domestic Abuse Policy
Guideline	Substance Misuse in Pregnancy
Flowsheet	Child/Young person was not brought to an appointment
Guideline	Berkshire Multiagency Guidance on the Management of Concealed Pregnancy
Guideline	Postnatal Care of Mother and Baby and Transfer to Another Hospital

Guideline	Postnatal visiting in the Community and Postnatal transfer to the Health Visitor
Guideline	Antenatal and Newborn Screening
Guideline	Antenatal Care and Booking
Guideline	Care of pregnant women with complex psycho-social needs
Guideline	Maternity Services Record keeping
Guideline	Translators and Interpreting in Maternity