Guideline for Women Who Present With Concealed Pregnancy

INITIATED BY:	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
APPROVED BY:	Antenatal Forum
DATE APPROVED:	June 2020
VERSION:	One
OPERATIONAL DATE:	June 2020
DATE FOR REVIEW:	4 years from date of approval or if any legislative or operational changes require
DISTRIBUTION:	Midwifery, medical and neonatal staff at Cwm Taf University Health Board. Via SharePoint

FREEDOM OF INFORMATION STATUS: Open

Guidelines Definition
Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments
If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person

Equality Impact Assessment Statement
This Procedure has been subject to a full equality assessment and no impact has been identified.

Contents

Definition

- Women who book late in pregnancy (at or after 20 weeks gestation)
- Women who are unbooked and present as an emergency admission
- Women who are unbooked and present in labour
- Women who transfer their maternity care after 20 weeks

Pregnancy which is unbooked for antenatal care after 20 weeks Where a woman, "through fear, ignorance or denial, does not accept or is unaware of the pregnancy in an appropriate way" (Sadler 2002).

There are 4 main recognised types of unbooked pregnancies;
Undetected: where both the woman and her carers are unaware that she is pregnant
Conscious concealment: where the woman is aware of her pregnancy and is emotional bonded to the unborn baby but does not tell anyone.
Conscious denial: where the woman has physical awareness of her pregnancy, but lacks emotional attachment
Unconscious denial where the woman is not subjectively aware of her pregnancy and genuinely does not believe the signs of pregnancy or even the birth of the baby
Concealed Pregnancy is rare; a study in South Wales, published in 2006, found an incidence rate of 1 in 2,500(Nimal et al 2006).

The reason for an unbooked pregnancy will be the key factor in determining the risk to mother and baby. The pregnancy must be considered as high risk due to lack of assessment of the maternal history, gestational age and health of the pregnancy. Considerations need to be made to the findings of the MBRACE (2014) report which

identified that women that book late or are unbooked are at higher risk of maternal and fetal complications.

Why do women conceal their pregnancies?

There are a variety of reasons which may include:

- Mental illness e.g. Psychosis, PND,
- Substance misuse
- Fear of disapproval of pregnancy
- Unwanted pregnancy
- Too late to terminate 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"
- Domestic Abuse
- Language Barrier
- Trafficking or Forced marriage

What are the consequences?

For the baby	For the mother
Prematurity Low birth weight Stillbirth Exposure to harmful substances (which may have a tetrogenic effect) Withdrawal of substances used by mother Neonaticide (the deliberate act of a parent murdering their own child during the first 24 hours of life). Neonatal death Infanticide Abandonment Neonatal morbidity	Lack of antenatal care Unassisted delivery Maternal Morbidity Poor attachment and bonding Lack of preparation for baby Guilt Legal consequences

Antenatal Presentation

When a woman books after 20 weeks gestation the midwife should complete the booking interview and offer screening tests as appropriate to her presumed gestation. Ultrasound scan to be offered to estimate gestation as soon as possible. Serial growth scans as per guidelines to be arranged. Bloods should be taken for FBC, and ante natal screening tests including, Rhesus status and antibody screening, group and save, HIV testing, syphilis and Hepatitis B after informed consent has been obtained.

- If the woman is more than 23+6 weeks gestation, the sample should be marked as rapid.
- If the woman is more than 36+6 weeks gestation, the sample should be marked as urgent.

The midwife should ensure the woman is seen in an obstetric clinic within 2 weeks of the 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. Women where English is not their first language the consideration of an interpreter. If child protection issues are identified the midwife should inform the woman of plans to refer to Children Services in respect of a concealed pregnancy and share the information to ensure access to appropriate services and support. The woman's GP needs to be informed of a concealed pregnancy and this recorded on her GP record as it can indicate a risk of further concealed pregnancies in the future.

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 Services department should be informed as per the alert.

A new set of notes can be obtained in antenatal clinic (24 hours a day) and a hospital identification number can found by telephoning medical records. There is no service for accessing a hospital number out of hours but it should be acquired at the earliest possible opportunity Monday – Friday 0900 - 2000.

Initial assessment is of paramount importance in established labour. As much information as possible should be taken as follows;

- Assessment of whether the woman is in labour or not is important, as birth may be imminent. In which case the safe delivery of the baby is paramount.
- An abdominal palpation is important to identify the gestation, the fundal height should be measured. Palpate any contractions and identify the lie and presentation of the baby.
- Confirm cephalic presentation and engagement of the presenting part before a vaginal examination is undertaken as care must be taken due to a lack of information on the location of the placenta. If the senior obstetrician on duty can perform a USS then this would be beneficial.
- Continuous monitoring to assess and monitor fetal well being
- Paediatricians should be alerted due to lack of information on gestation, antenatal screening etc.
- Bloods should be taken for FBC, and ante natal screening tests including, Rhesus status and antibody screening, group and save, HIV testing, syphilis and Hepatitis B after informed consent has been obtained. These should be sent urgently. The health professional should contact the consultant microbiologist/virologist to ask for a risk assessment and to establish the urgency of testing and management of the woman whilst the results are awaited.
- It is very difficult to ask questions while a woman is in labour but a physical and social risk assessment should take place at an appropriate time to ensure that every woman has an individual plan for her care. It is vital that midwives undertake a full risk assessment in order to establish past and current obstetric and medical history This will include;
    - Past history or family history of thromboembolism

- Body Mass Index (BMI) calculated (this may not be possible if the woman is in labour).
- Any history of medical problems, such as diabetes or hypertension
- Questions about domestic violence as part of their social history. Women should be given the opportunity to discuss their pregnancy with a midwife in private. Partners or family members should be excluded at this discussion where at all possible.
- Previous psychiatric history, its severity, care received and clinical presentation. Women who have a past history of serious psychiatric disorders should be referred to a psychiatrist and a management plan should be made. Referral to the perinatal mental health service can be offered. If urgent referral to the CRISIS team if the client is in the community setting or the mental health liaison team if an inpatient.

Postnatal care

- Counselling may need to be offered if issues arise such as domestic violence, unwanted baby, adoption etc.
- Closely observe for signs of attachment
- Involve Children services if required
- Parent craft session on a one to one basis may be required
- Support to establish infant feeding
- Support in the post-natal period and transfer into care of community midwife and health visitor.
- The GP should be informed
- Advice for services which are able to provide items for baby for clients who have limited means. Such as **Cwtch baby**

bank a registered charity who take referrals from midwives and health professionals 02921 322040

References

Nirmal, D.Thijs, I. Bethel, J. Bhal, P. (2006) The incidence and outcome of concealed pregnancies among hospital deliveries: an 11 year population-based study in South Glamorgan. Journal of Obstetrics and Gynaecology. Volume 26 (2) p.118-121.

Wessel, J. Buscher, U. (2002) Denial of pregnancy: Population based study. British Medical Journal (International Edition) February 23rd.Volume 324, Issue 7335 p.458.

MBRRACE 2014 Reports | MBRRACE-UK | NPEU Accessed May 2019