St Helens and Knowsley Teaching Hospitals NHS Trust

Guideline for Concealed Pregnancy and Birth (Including management in the Emergency Department)

Version No: 3

Document Summary:
This guidance is intended for professionals who may encounter women who conceal the fact that they are pregnant or where there is a known previous concealed pregnancy. Also includes management in the Emergency Department.

Document status	Approved	
Document type	Guideline	**local**
Document number	STHK0592	
Maternity Code	C016	
Approving body	Obstetrics & Gynaecology Clinical Governance and Quality Group	
Date approved	07/09/2022	
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Review date	**30/09/2025**	
Accountable Director	Director of Nursing, Midwifery & Governance	
Policy Author	Lead Midwife for Safeguarding and Lead Nurse for Safeguarding	
Target audience	Specific staff group	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments.

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information	
Title	Guideline for Concealed Pregnancy and Birth (including management in the Emergency Department)
Directorate	Surgical
Brief Description of amendments:	
This guideline supersedes Version: 2	
Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes

Section 2 – Consultation Information			
Consultation Completed	☐ Trust wide ☐ Local ☑ Specific staff group		
Consultation start date	Click here to enter a date.	**Consultation end date**	Click here to enter a date.

Section 3 – Version Control

Version	Date Approved	Brief Summary of Changes
1	June 2017	New SOP
1.1	March 2018	CP-IS added to the guideline as Appendix 4 and 5. For approval through the risk management group to be held on the 21st March 2018
2	August 2019	Reformatted the guideline to include recommendations from NICE guidance 121 as follows: to include further reasons why women conceal their pregnancies and actions to take.
3	September 2022	Full review by Allison Wright and the Safeguarding team and also the ED. This guideline has been through the ED governance meeting. Amendments made to change cause for concern to MISF and the mention of the substance misuse midwife removed. Changes made to the email contacts for safeguarding.

Section 4 – Approval *– To be completed by Document Control*			
Document Approved	☑ Approved ☐ Approved with minor amendments		
Assurance provided by Author & Chair	☑ Minutes of Meeting ☐ Email with Chairs approval		
Date approved	07/09/2022	**Review date**	30/09/2025

Section 5 – Withdrawal *– To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by Author & Chair	☐ Minutes of Meeting ☐ Email with Chairs approval
Date Withdrawn:	Click here to enter a date.

Contents

1. Scope

This guidance is intended for professionals who may encounter women who conceal the fact that they are pregnant or where there is a known previous concealed pregnancy. This guidance should be applied in conjunction with any internal agency procedures and Safeguarding guidance.

2. Introduction

Confidential enquiries into maternal and child deaths have consistently identified underlying social factors as having a significant influence on poor birth outcomes for mothers and babies. In the 2007 Confidential Enquiry into Maternal and Child Health (CEMACH), women living in areas of England with the highest deprivation scores were found to have a mortality rate due to direct and indirect causes during pregnancy and up to 42 days after giving birth that was five times higher than the rate for women living in areas with the lowest score. ***Seventeen per cent of women who died had a concealed pregnancy, no antenatal care or had registered with an antenatal service after the 22nd week of pregnancy.***

3. Statement of Intent

While concealment by its nature limits the scope of professional help, experience demonstrates that better outcomes can be achieved by co-ordinating an effective inter- agency approach once the fact of the pregnancy is established. This will also apply to future pregnancies where there has been a previous concealed pregnancy.

4. Definitions

A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health agencies. It is also where a woman is not aware 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 for the duration of the pregnancy.

Concealment of pregnancy may be revealed 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.

Child protection issues may arise where a pregnancy is disclosed late. For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy. Also, where there is no evidence of antenatal care in the UK or abroad.

It is possible that a 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.***

It is also recognised that there will be situations where a baby is not declared. It is an offence to not register the birth of a child whether born alive or stillborn under the birth registration and death act 1953. It could be seen as neglectful of the child if there is failure to seek the appropriate care either pre or post birth.

5.8 Safeguarding Team

The Maternity Safeguarding Team have a responsibility to ensure staff are sufficiently supported to carry out their safeguarding responsibilities in line with Trust Policy , and to, where necessary, coordinate and contribute to multi agency meetings and assessments.

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust including and ensuring that this guideline complies with all legal, statutory and good practice guidance requirements and is implemented effectively and efficiently.

5.2 Director of Nursing, Midwifery and Governance

The Director of Nursing Midwifery and Governance is the Accountable Director for this Guideline.

5.3 Clinical Director and the Obstetrics Team

The Clinical Director and his/her team has primary responsibility for the care of high risk women attending Maternity Services, and will ensure that all aspects of the woman's care is effectively communicated to the woman, using this guideline if necessary. The team will also communicate with other specialities when there is a clinical indication which requires this.

5.4 Head of Midwifery

The Head of Midwifery is accountable to the Trust Board for assuring compliance with this guideline within maternity services and ensuring that the guideline is reviewed and updated by the specified review dates.

5.5 Matrons

The Matrons within maternity and gynaecology services are responsible for ensuring clarity and compliance with training requirements for this guideline. Matrons are responsible for ensuring staff are aware that up to date clinical guidelines are available on the intranet and in hard copy folders on delivery suite only.

5.6 Ward Manager/Clinical Manager

The ward manager is responsible for ensuring that all staff working in their clinical areas are fully aware of their responsibilities within this guideline and any specific pathways that are available.

5.7 All Staff

All staff are responsible for ensuring they are familiar with Trust procedural documents and local procedural documents. Staff are aware that up to date clinical guidelines are available on the intranet and in hard copy files in Delivery Suite only.

5.8 Safeguarding Team

The Maternity Safeguarding Team have a responsibility to ensure staff are sufficiently supported to carry out their safeguarding responsibilities in line with Trust Policy , and to, where necessary, coordinate and contribute to multi agency meetings and assessments.

6. Concealed Pregnancy and Birth

6.1 Reasons for Concealment

- Studies have shown that late commencement of antenatal care is associated with 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.

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

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

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

- A woman or girl 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.

- A woman who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant.

- A pregnancy may be concealed in situations of domestic violence. Domestic abuse is more likely to begin or escalate during pregnancy.

- In some religions and cultures, a pregnancy outside of marriage may have life threatening consequences for the woman involved. In these instances, women have been known to conceal their pregnancy or ‘disappear’ to avoid bringing shame to the family.

- Other reasons: Homelessness, trafficking, undocumented migrant status, female genital mutilation, maternal mental health issues.

- Free birth may be planned and occurs when a woman chooses to give birth alone. In some instances, women engage in antenatal care, but others choose to avoid all antenatal care whatsoever.

6.2 Implications and Indicators of a Concealed Pregnancy

The potential risk to a child through the concealment of a pregnancy is extremely hard to predict. One key implication for the pregnancy is that there is no obstetric history or record of antenatal care prior to the birth of the baby which can impact on the management of care. Some women 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.

In relation to the safeguarding issues in concealed pregnancy, the focus is on the child regardless of whether unborn or born.

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.

6.2.1 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

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

6.3 Risks/Protection Issues

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.

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.

Lack of antenatal care can mean that any potential risks to mother and child may not be detected. Underlying medical conditions and obstetric problems will not be revealed. It may also lead to inappropriate advice being given; such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy.

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

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. Nirmal et al (2006) identify denial of pregnancy as a likely precursor of poor adaptation postpartum and highlights the need for increased monitoring in the postpartum period.

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 woman's partner.

6.4 Where Suspicion Arises – Action to take

There is a need to balance the need to preserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. There will be a point at which the child's welfare overrides the mother's right to confidentiality. This is a relevant consideration even though the baby is in utero.

Where there is a strong suspicion that a pregnancy is being concealed, it may be necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained. Every effort should be made by the person alerted to suspicion of concealed pregnancy to encourage the (young) woman to obtain medical advice.

Where anyone has such concerns they should contact anyone in another agency known to have involvement with the young/ woman so that a fuller assessment of the available information and observations can be made.

The concern should be discussed with the Maternity Safeguarding Team and consideration given to a referral the Children's Social Care.

6.5 When Concealment Is Revealed

Where a concealed pregnancy is identified, the key question is 'why has the pregnancy been denied / concealed? The circumstances leading to concealment of pregnancy need to be explored individually. A MISF should be completed and the Safeguarding Team informed to co-ordinate the necessary services.

While midwifery services will be the primary agency involved with women after the concealment is revealed, either late in pregnancy or at the birth, any of the agencies may be the ones to whom the woman either discloses, or in whose presence labour commences. All agencies should ensure that information about the concealment is shared with other relevant agencies, to ensure its significance is not lost and to ensure that potential future risks can be fully assessed and managed.

6.6 Women presenting in the Antenatal Period with a Concealed Pregnancy

- Complete an urgent booking Short/Full
- Establish reason for concealment and if appropriate refer to specialist services (e.g. mental health team, drug and alcohol team)
- For a woman with no antenatal care who has difficulty understanding and reading English, an interpreter will be provided
- Discuss with Maternity Safeguarding Team with a consideration for a referral to Children's Social Care for a pre Birth Assessment, dependant on identified safeguarding concerns, gestation, vulnerability factors etc.
- If the mother is aged under 18 a referral should be considered in respect of the mother as well as the unborn
- Complete an individualised care plan for the remainder of the antenatal period. which will include appointments, ultrasound scans, full booking bloods and antenatal screening tests
- Inform the Community Midwives
- Inform the General Practitioner and Health visitor via a MISF
- ***Complete a Datix.***

6.7 Women presenting to the maternity Department in labour with a Concealed / Unbooked pregnancy

- Complete an urgent booking Short/Full
- Gather any relevant information including reason for concealment / avoidance of ante natal care
- Make an immediate referral to Children's Social Care
- Inform the maternity Safeguarding Team

6.8 Woman Presenting to the Emergency Department

(Complete Appendix 2)

If the woman has ***already delivered*** on route to Hospital or in the Emergency Department then all necessary care is given by the ED staff including information gathering and the Delivery Suite will be contacted to request a Midwife to assist. When safe to do so, transfer the woman and her baby to the Delivery Suite for on-going care. **RETAIN THE PLACENTA.**

If the woman has ***delivered prior to arrival in ED and the baby is Stillborn*** Contact the Paediatric Registrar. Contact the Delivery Suite immediately to request a Midwife and Obstetric Registrar. Comfort the mother and relatives. The midwife will transfer the mother and her baby as soon as possible to a bereavement room on the Delivery Suite. Ensure that timings of the delivery are documented if known.
RETAIN THE PLACENTA.

If the woman is ***about to deliver*** the Delivery Suite will be contacted and a Midwife requested urgently. A Paediatric Registrar would be contacted to attend the delivery. Resuscitation would be commenced on delivery if an Intrauterine Death had not been confirmed and the baby is over 24 weeks gestation (if gestation known) and requires resuscitation. Resuscitation would be discussed with a Paediatric Consultant before it is discontinued. All the necessary paperwork would be completed on the Delivery Suite. Ensure that timings of the delivery are documented.
RETAIN THE PLACENTA.

If the woman is ***in labour*** following discussion with the Shift Leader / Obstetric Registrar and if the woman's condition is stable arrange transfer to Delivery Suite. The woman will be accompanied by a Midwife. Aim to gather as much information about the woman as possible whilst providing essential care and support to deliver the baby. **RETAIN THE PLACENTA.**

In all cases an immediate referral must be made to Children's Social Care

Babies brought into or delivered in the emergency department and are confirmed as stillborn, must not be booked into ED system as babies are *registered on maternity IT system only.*

6.9 Continuing Management within the Maternity Department (post-delivery)

- Information would need to be ascertained as to whether there is any ***substance misuse*** and if there is involvement with any drug team. If there is suspicion but the woman is denying, then further information may be obtained from contacting drug teams or the community midwife caring for the woman, checking on EDMS (especially Emergency Department admissions).

- .As part of the information gathering it would need to be established whether the woman has any ***mental health needs***, mental illness, learning disabilities etc. The specialist midwife for mental health.

- In all cases consider a mental health assessment

- Any relevant medical investigations / screening tests should be completed

- If mothers blood group not known a cord sample should be taken to assess babies blood group and a swab taken for culture and sensitivity (to exclude GBS).

- **Safeguarding:** The Maternity Safeguarding Team in conjunction with ward staff should liaise with Children's Social Care to ascertain further information in relation to the mother and other family members. **The midwife caring for the woman should attend any social care meetings being held prior to transfer into the community setting.**

- Midwives should be alert to and document the level of attachment demonstrated on the post-natal ward, a parenting assessment tool must be completed

- A suitable and safe discharge plan should be agreed with multi agency partners with oversight form the Maternity Safeguarding Team, relevant safeguarding documentation should be completed prior to discharge and shared with all relevant professionals.

- In the cases of still birth/ neonatal death the bereavement midwives will offer a full package of care for the woman and her family.

6.10 Community Midwife Follow up

Following discharge post-natal care should be provided as per Trust Policy / discharge plan. The Community Midwife should be fully informed of the circumstances of the pregnancy, delivery and discharge plan including ongoing involvement with Children's Social Care. Any concerns raised during this period should be discussed with the Maternity Safeguarding Team and, if applicable, the allocated Social Worker.

6.11 Police involvement

The Police 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 the multi-agency Strategy Meeting and consider the circumstances and to decide whether a joint Child Protection investigation should be carried out.

Factors to consider will be the age of the woman who is suspected or known to be pregnant, and the circumstances in which she is living to consider whether she is a victim of potential victim of criminal offences. In all cases where a child has been harmed, been abandoned or died it will be incumbent on the Police and Children's Social Care to work together to investigate the circumstances.

Where it is suspected that neonaticide or infanticide has occurred or a newborn is thought or found to have been harmed then the Police will be the primary investigating agency.

6.12 Storage of Placentae in Concealed Pregnancy

The placenta should be placed in formalin, labelled with the mother's details and taken to the mortuary. The coroner suggested that we retain the placenta until such time that the baby has been discharged in a healthy condition.

7. Training

As per training needs analysis.

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1	Compliance with the guideline

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Each case complies with the standards in the guideline appropriate to the incident.	Safeguarding Midwives	Individual case review using the standards	Individual Case Review Reported on Datix	O&G Clinical Governance Quality and Safety Group	Safeguarding Midwives

9. References

No	Reference
1	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
2	National Institute for Health and Clinical Excellence (2010) Pregnancy and Complex Social Factors: a model for service provision for pregnant women with complex social factors. (September 2010). www.nice.org.uk/guidance/cg110
3	National Institute for Health and Care Excellence (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies NICE guideline Published: 6 March 2019 www.nice.org.uk/guidance/ng121
4	Confidential Enquiry into Maternal and Child Health (CEMACH) (2007) Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer -2003 – 2005

10. Related Trust Documents

No	Related Document
1	S011 Maternity Safeguarding Children Standard Operational Procedure for Women with Safeguarding Issues receiving care from STHK Maternity Services (May 2017)
2	Policy for the Management of Female Genital Mutilation (June 2019)

11. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes. Cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

Equality Analysis			
Title of Document/proposal /service/cost improvement plan etc:	Guideline for Concealed Pregnancy and Birth (including management in the Emergency Department)		
Date of Assessment	11/07/2022	**Name of Person completing assessment /job title:**	Ann Finch
Lead Executive Director	Director of Nursing, Midwifery & Governance		Audit and Guideline Midwife

	Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:	**Yes / No**	**Justification/evidence and data source**
1	Age	NO	
2	Disability (including learning disability, physical, sensory or mental impairment)	NO	
3	Gender reassignment	NO	
4	Marriage or civil partnership	NO	
5	Pregnancy or maternity	NO	Maternity Guideline
6	Race	NO	
7	Religion or belief	NO	
8	Sex	NO	Maternity Guideline
9	Sexual Orientation	NO	
	Human Rights – are there any issues which might affect a person's human rights?	**Yes / No**	**Justification/evidence and data source**
1	Right to life	NO	
2	Right to freedom from degrading or humiliating treatment	NO	
3	Right to privacy or family life	NO	
4	Any other of the human rights?	NO	

Lead of Service Review & Approval	
Service Manager completing review & approval Job Title:	Jacqui Kourellias
	Quality and Safety Matron

12. Appendix 1 Management of Concealed Pregnancy and Birth in the Emergency Department

Woman Attends Hospital

When a woman attends Hospital via the Emergency Department and a concealed pregnancy is ***suspected or confirmed*** the following actions are essential to ensure optimal Clinical and Safeguarding Care provision for the woman, baby and her family

Babies brought into or delivered in the emergency department and are confirmed as stillborn, must not be booked into ED system as babies are *registered on maternity IT system only*

Management of Concealed Pregnancy & Birth

If the woman has ***already delivered*** on route to Hospital or in the Emergency Department then all necessary care is given by the ED staff including information gathering and the Midwife called to assist. When safe to do so, transfer the woman and her baby to the Delivery Suite for on-going care. **RETAIN THE PLACENTA**

If the woman has ***delivered prior to arrival in ED and the baby is Stillborn*** – Contact the Paediatric Registrar. Contact the Delivery Suite immediately and request a Midwife and an Obstetric Registrar. Comfort the mother and relatives. The midwife will transfer the mother and her baby as soon as possible to a bereavement room on the Delivery Suite. Ensure that timings of the delivery are documented. **RETAIN THE PLACENTA.**

If the woman is ***about to deliver*** the Delivery Suite will be contacted and a Midwife requested urgently. A Paediatric Registrar will be contacted to attend the delivery. Resuscitation would be commenced on delivery of the baby if an Intrauterine Death had not been confirmed and the baby is over 24 weeks gestation (if gestation known) and requires resuscitation. Resuscitation would be discussed with a Paediatric Consultant before it is discontinued. All the necessary paperwork would be completed on the Delivery Suite. Ensure that timings of the delivery are documented. **RETAIN THE PLACENTA.**

If the woman is ***in labour*** following discussion with the Shift Leader / Obstetric Registrar and if the woman's condition is stable arrange transfer to Delivery Suite. The woman will be accompanied by a Midwife. Aim to gather as much information about the woman as possible whilst providing essential care and support to deliver the baby. **RETAIN THE PLACENTA**

- Information would need to be ascertained as to whether there is any ***substance misuse*** and if involvement with any drug team. If there is suspicion but the woman is denying, then further information may be obtained from contacting drug teams or the community midwife caring for the woman, checking on EDMS (especially Emergency Department admissions).
- .As part of the information gathering it would need to be established whether the woman has any ***mental health needs***, mental illness, learning disabilities etc. Contact the Specialist Midwives for mental health for support.
- ***The Safeguarding Team*** must be informed of the woman's admission which includes the Safeguarding Midwives who will co-ordinate information gathering and elicit whether the woman has social service involvement etc.

Post Delivery Care - COMPLETE A DATIX

Postnatal Care provision will include the documentation of all details relating to the woman and her baby on the electronic patient record (Medway) a short booking will need to be done initially and booking bloods obtained with consent which will include screening tests.

The woman and her baby will not be discharged home until relevant checks have been made with Children's Social Care (according to geographical area), to identify if there is any involvement with the family or any safeguarding issues that may prevent discharge.

13. Appendix 2 - Emergency Department Stillbirth Proforma

(Concealed / Unbooked Pregnancy)

Date:	Triage Time:
Mothers Name & DOB :	Confirmed Pregnancy? Y/N Has mother been booked in by maternity services? If YES which Hospital:
Date of Last Menstrual Period:	Expected delivery date:

Date of Incident:	Time of Incident:
Where did the incident take place: (please circle) Family Home/ Public Place/ Other	If other / public place please give details:

Please provide a brief description of events leading up to today consider last USS, when mother felt fetal movements, any pain / PV loss, any complications during pregnancy :

Time arrived in Emergency Department:……

Seen by:……

Designation:……..

Condition of Baby on arrival to ED and any procedures performed to be documented by most senior doctor: Date & Time of confirmed stop of interventions in ED :

Family Social History

Previous Pregnancies Y/N	Previous Stillborn Y/N If yes please provide details: Previous RIP Y/ N If yes please provide details:
Live Births Names Address and DOB of children	Name, Address & DOB of Father
Any History of social service involvement with family? Y/N	Names and DOB of ALL adults who live with mum :

If yes please document Name, Contact Number and details of involvement	
Additional Safeguarding information:	

PLEASE READ CO16 Standard Operational Procedure – Concealed Pregnancy and Birth (Including management in the event of a stillbirth in the Emergency Department) ENSURE SOCIAL CARE REFERRAL IS CONSIDERED &COMPLETED IF REQUIRED

Date and Time of Transfer to Delivery Suite: **HANDOVER OF CARE:** Name of Midwife _____
Is a Social Care referral required? (Please circle) YES NO
Date referral made to Social Services:
Referral made to : (Please circle) ST HELENS HALTON KNOWSLEY WARRINGTON LIVERPOOL OTHER Name and contact number of person taking referral?
PLEASE NOTE **Babies brought into or delivered in the emergency department and are confirmed as stillborn, must not be booked into ED system as babies are registered on maternity stillbirth system only.** **Care and information gathered is to be documented in the mother's records or on this proforma.** **Please email the Lead Nurse for Safeguarding lisa.forshaw2@sthk.nhs.uk and the Lead Midwife for Safeguarding in Maternity Services safeguarding.confidential@nhs.net to inform them of the incident before transfer to Delivery Suite where a different process is followed for stillbirths.**

Signature of Discharging Doctor ……
Signature of Transferring nurse……..

14. Appendix 3 - How CP-IS works

CP-IS connects local authority children's social care systems with those used by NHS **unscheduled care settings**, such as Accident and Emergency, walk-in centres, and **maternity units**.

It ensures that health care professionals are notified when a child or unborn baby with a child protection plan (CPP) or looked after child status (LAC) is treated at an unscheduled care setting.

CP-IS is a secure system with clear rules governing access. Only authorised staff involved with the care of a child can access the information.

The contact details will be on the system for the Children's social care in that holds the case.

Social care teams are alerted automatically when a child in their care attends an unscheduled care setting **every time the system is accessed**.

System use – the key principles

CP-IS is for use on case classed as unscheduled, therefore patients who are not booked with our services or they may have no maternal notes.

- The system is **ONLY** accessed for pregnant mothers that are receiving direct treatment within the department- **please do not use the system to check out safeguarding concerns on cases.**
- The information we receive from searches shows live and current data.
- The details of the plan will not be visible – normal safeguarding process will be followed if attendance is of a concern.
- The name and the title of staff requesting information is recorded and becomes part of an attendance record that is visible to any other consequent departments that access the child records.
- The staff can see a record if children/mothers are accessing multiple organisations.

CP – IS SOP

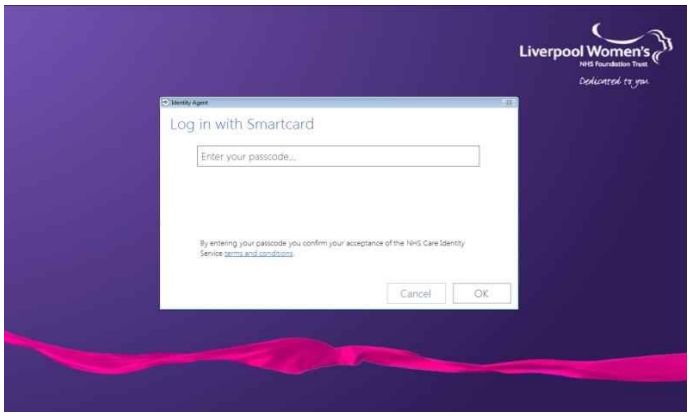
Triage & Delivery Suite

The band 7 delivery suite coordinators and the Midwifery Safeguarding Children Team have access to CP-IS and should access the system for the following situations:-

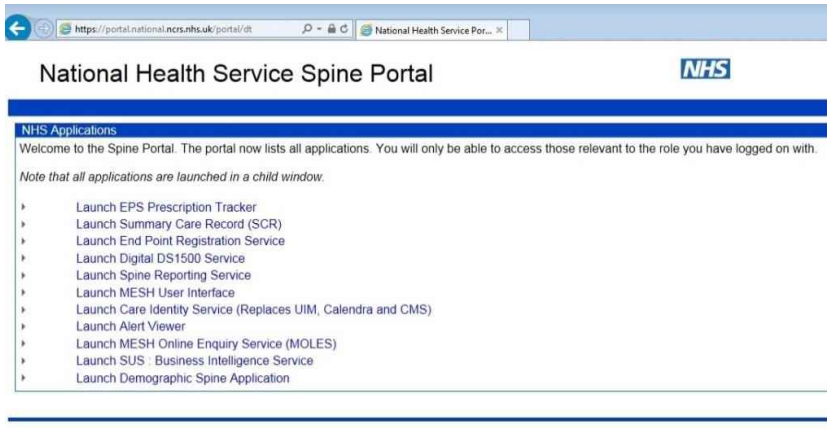
1. Any mother that is **unknown** to Whiston Maternity services (they may have been admitted via emergency department or accessed directly from ambulance services.)

15. Appendix 4 - CP-IS User Guide

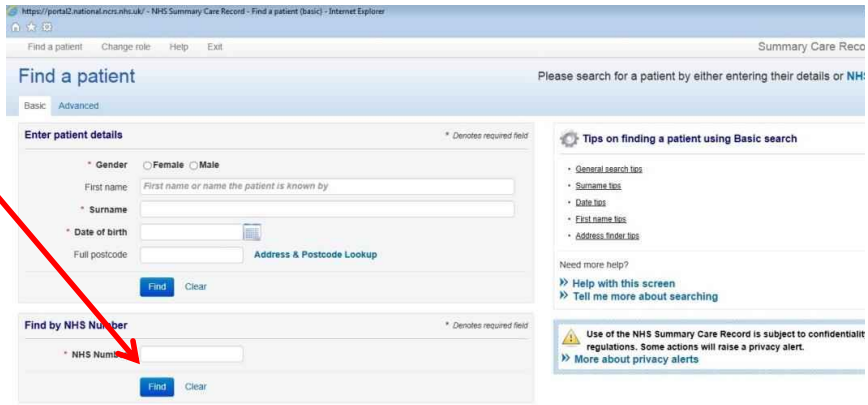
1. Insert SMARTcard into Keyboard or separate reader
2. Input Passcode



3. Double Click NHS Spine Portal Logo
4. Once loaded, click Summary Care Record (SCR)

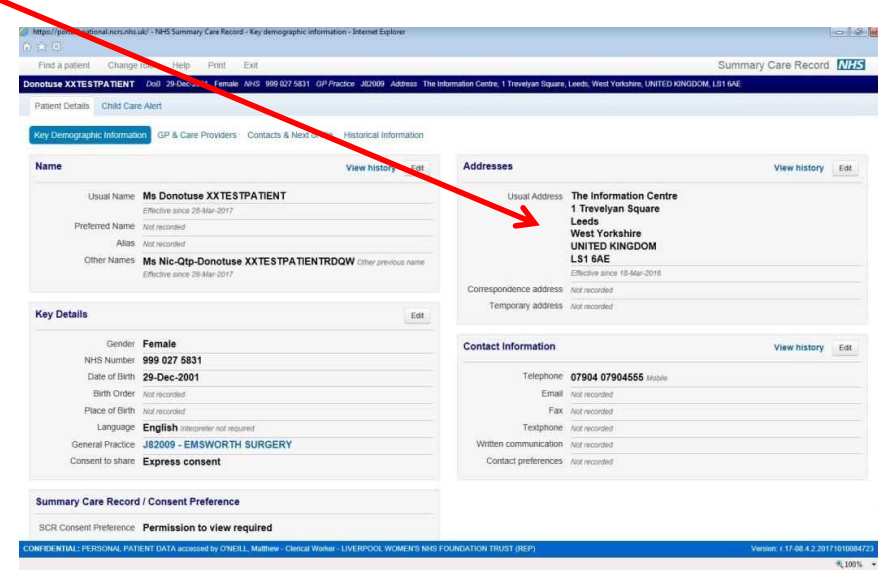


5. Once loaded, type in patient NHS number or name and Date of Birth



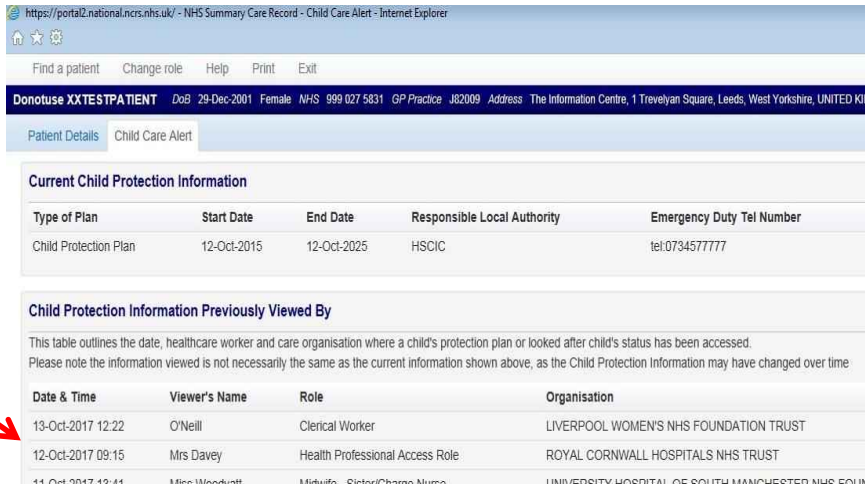
6. Patients Details will load. **Please validate details.**

7. If a Child Care Alert is visible then click tab, if not please click Exit

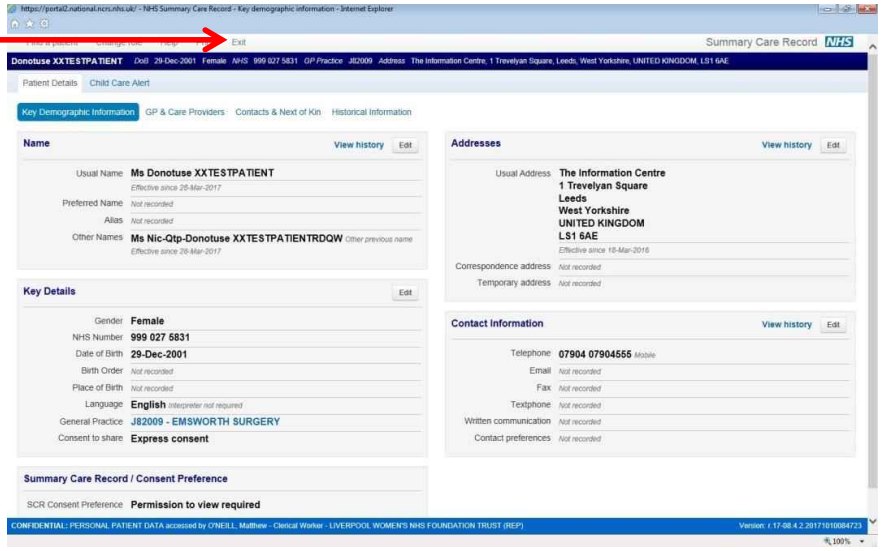


8. Child Care Alert will load. If there are concerns relating to visit then follow Safeguarding processes (If appropriate contact Social Worker)

9. CP-IS will save the attendance and allows practitioners to view recent attendances to A&E



10. Once complete, **click exit**



We would like to acknowledge the Liverpool Women's for permission to duplicate the screen shots.