7. Once investigations, agreed at strategy meetings, are underway (even outside of the S47 framework) a clearly agreed plan needs to be in place regarding the frequency of contacts to be attempted with parents who are seeking to evade the oversight of agencies in these circumstances.

8. GP information sharing to child protection conferences and core groups should include all relevant information to assist ongoing risk assessment and planning.

Details have been changed to protect the identity and privacy of family members and professionals involved in this case.

For more Information contact: Steve Day, Safeguarding Standards & Quality Assurance Manager. Email: steve.day@northumberland.gov.uk
Telephone: 01670 623980

Keeping Children and Young People Safe from Harm, Abuse and Neglect

Northumberland Safeguarding Children Board

Highlighting Lessons from Management Review

Local

Date of Review: July 2012
Local Authority: Northumberland
Name: Nathan

Outline

Nathan was born in March 2012 at the home of his father who was present at the birth. The Coroners report later confirmed that Nathan was still born and had not drawn independent breath. The cause of death is recorded as placental abruption.

Nathan's parents have six children, the eldest three are adults and the three youngest children are no longer in their care. One is subject to a Care Order and in foster care, one was removed at birth and subsequently adopted, and one was removed at six weeks old and placed for adoption.

There are historic concerns around neglect and poor parenting. Mother went to great lengths to conceal two previous pregnancies. One of the babies was delivered under an alias in Scotland (with assistance from 'Mothers for Justice') and one was born in London.

Agencies became aware that mother may be pregnant again during September 2011 but she strongly denied this and continued to conceal her pregnancy.

Lessons Learned and practice pointers

There is no doubt that working with this family presented serious difficulties for all professionals due to the level of collusion in the wider family, hostility from father and dishonesty from mother regarding her pregnancies. The NSCB has acted to put in place new and comprehensive policy and procedural guidance for professionals dealing with this difficult area – Concealment and denial of pregnancy and birth http://northumberlandlscb.proceduresonline.com (Chapter 1.4.30). In the following sections it deals specifically with the major lessons arising from this review:

1. Where a pregnancy is denied but the professional has reasonable grounds to suspect the pregnancy is concealed or denied, a referral to Children's Social Care should be made.
2. Where a strong suspicion that there is a concealed or denied pregnancy remains, the welfare of the unborn child will override the mother's right to confidentiality irrespective of whether consent to disclose can or has been obtained, a referral to Children's Social Care must be made. Children's Social Care will then convene a multi-agency strategy meeting. The strategy meeting will consider all the information available and may decide that the situation requires further investigation to determine the level of risk and how best to take the matter forward.
3. If a health professional, including those who provide help and support to promote children's or women's health suspects or identifies a concealed or denied pregnancy, they must discuss the matter with their line manager or Named Child Protection Advisor, who will advise on the appropriateness of a referral to Children's Social Care.
4. All health professionals should give consideration to the 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 childbearing age whether they might be pregnant. If suspicions are raised that a pregnancy may be being concealed or a pregnancy is confirmed maternity services should be contacted. Where the pregnancy is confirmed, the expectant mother should be transferred to the labour ward for a full assessment of need. Should the patient refuse transfer to the labour ward a Midwife should attend the A and E department to ensure an appointment for a scan and with the community midwife is made prior to discharge. This must be recorded in the discharge notes and an appropriate note made to the referring GP for follow up with the patient.
5. Where a G.P has significant reason to believe an expectant mother is pregnant, but she refuses all attempts to persuade her to undertake further investigations, further action needs to be taken. This should include discussion with the Midwife, Health Visitor or School Nurse, (as appropriate), any of whom may be able to pursue the matter further or refer on to Childrens Social Care. It may be helpful to discuss the concerns with the Designated (or Named) Doctor or Nurse for Child Protection.
6. Children's Social Care may receive a referral from any source which suggests a pregnancy is being concealed or denied. In all cases a multi- agency strategy meeting will be convened, involving the General Practitioner, Police, midwifery services, Named Nurse safeguarding children, legal advisor and other relevant agencies to assess the information and formulate a plan.