Serious Case Review

Overview Report

Child LF

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Contents

Key: Family Identifiers

MBLF	Mother of Baby LF
GFBLF	Maternal Grandfather of Baby LF
GMBLF	Maternal Grandmother of Baby LF

Introduction

1. The Lancashire Safeguarding Children Board (LSCB) agreed on the 2nd February 2016 to commission a Serious Case Review (SCR) into the death of Baby LF who was born and died on the 25th November 2014.
2. At the time of the birth, Baby LF's mother, MBLF was 29 years old. MBLF concealed her pregnancy and gave birth alone, unassisted in a bathroom at home. MBLF lived with her parents at that time. It is believed that Baby LF died shortly after birth. The initial belief was that Baby LF was stillborn however a post mortem examination revealed that the baby had taken a breath. The post mortem examination confirmed that Baby LF had been born full term.

Context

3. There was limited history of agency involvement with MBLF and her family and they were not known beyond universal service provision and a termination of pregnancy service. However MBLF did seek a termination of pregnancy when she appeared to be over 30 weeks into the pregnancy and this contact with agencies was crucial and is covered in more detail later in this report.
4. In this case MBLF confirmed that she both concealed and denied her pregnancy.
5. It is the opinion of the Lead Reviewer and every practitioner who has come into contact with MBLF since the death of Baby LF that she is an extremely vulnerable woman who sometimes struggles to comprehend things. These difficulties have been compounded by MBLF's lifetime experience of parental control and abuse which she both witnessed and was subjected to.
6. Research exploring concealment and denial of pregnancy is relatively recent and has primarily focussed on attempting to understand the characteristics of women who conceal

or deny their pregnancy (Earl et al, 2000; Friedman, 2005; Vallone, 2003; Nirmal et al 2006; Wessel & Buscher, 2002).

7. It appears from her own account that MBLF both concealed *and* denied her pregnancy and the review of the literature indicates that the measurement of the nature and extent of this issue not only varies on the basis of the exact definition of concealed or denied pregnancy used but also as a result of the methodology adopted across the limited research studies conducted.
8. The majority of the literature available appraises the exact definition of this phenomenon around various categories of denial described as pervasive, affective and psychotic denial (Friedman et al, 2007).
9. This SCR did not attempt to determine an exact application of the various definitions as denying and concealing a pregnancy are distinct concepts which are closely interlinked (Friedman et al, 2007) within a continuum of definitive behaviours.
10. There are clear challenges of predicting and identifying women likely to conceal/deny a pregnancy. Evidence suggests that there is no clear typology for women who conceal/deny their pregnancy (Jenkins et al, 2011). However, it should be noted that concealed/denied pregnancies are not regarded as an issue affecting very young women, in fact, women who conceal/deny their pregnancy are described as predominately single, educated or employed. Living within a rural area and the perceived family reaction to the pregnancy is also thought to be a potential contributory factor to denial/concealment (Thynne et al, 2012).
11. Upon reviewing the literature (and other published SCR reports) in relation to concealed pregnancy it becomes clear that there are challenges in predicting and identifying women and girls who may conceal or deny a pregnancy as there is no clear profile of women who do so. The challenge of assessing risk and need in relation to this very small cohort of women will be immense which in turn limits the opportunity for early help or support.

The SCR: Process and Methodology

12. The Local Safeguarding Children's Board (LSCB) agreed on the 2nd February 2016 to commission a SCR (SCR) into the death of Baby LF. The scope of this SCR was to cover the timeframe from 25th November 2012 to the date of Baby LF's birth and death on the 25th November 2014. It was agreed by the SCR Panel that any significant events prior to 25th November 2012 would also be included.
13. Unusually however; the Lead Reviewer and the SCR Panel agreed that information which came to light in the weeks immediately following Baby LF's death concerning MBLF's and GMBLF's experiences of abuse were highly relevant to understanding why MBLF had concealed her pregnancy and the role agencies could have played in supporting her.
14. The SCR Sub Group made a recommendation that the LSCB should conduct a proportionate, appropriate and participative SCR with the emphasis upon professional involvement, to address how agencies had worked together in this case, identify any learning, aggregate lessons from individual organisations and ensure that an improvement action plan was put in place.
15. The SCR was designed and led by Clare Hyde MBE, independent reviewer, from The Foundation for Families (a not for profit Community Interest Company). Ms. Hyde developed a review model that would enable participants to consider the events and circumstances, which led up to the tragic death of Baby LF. Ms. Hyde also authored this report.
16. The methodology used was the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).
17. This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of

the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final SCR report or in the action plan as appropriate.

18. This approach also takes account of work that suggests that developing over prescriptive recommendations has limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from SCRs 2009 -2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from SCRs can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.
19. An Expert Leads Panel was convened of senior and specialist representatives from agencies involved with the family in the time covered, to oversee the conduct and outcomes of the review. All panel members were independent of the family and casework. The role of the panel was to assist the Lead Reviewer in considering the evidence, formulating the recommendations and quality assuring this report.
20. There was very limited agency involvement with Baby LF's family however the following agencies were asked to provide a chronology and these were integrated into a combined chronology.

    - Lancashire Constabulary
    - GP Medical Practice

- NHS commissioned independent termination of pregnancy service
- Blackburn Diocese
- Blackpool Teaching Hospital NHS Foundation trust.

21. The Lead Reviewer considered the combined chronology in order to consider in detail the sequence of events and any key practice episodes that underpinned those events.
22. The LSCB SCR Sub Group agreed draft terms of reference for the SCR in addition to the terms of reference described in national guidance.
23. The SCR panel also considered further key lines of enquiry which were then included in the terms of reference. The terms of reference were:

    A. In relation to the pregnancy what was known amongst agencies and how was this shared within the multi-agency arena

    B. Is there any understanding within the information known to agencies that would help agencies to understand the reasons why women choose to conceal pregnancies?

    C. Is the board assured that the process of information sharing between Termination of Pregnancy provider organisation and GP's is robust particularly if a termination of pregnancy cannot be performed?

In addition; the Lead Reviewer included the following additional term of reference;

D. What does national and international research tell us about women with lifelong exposure to abuse and concealed pregnancy?

24. The SCR aimed to provide an innovative 'whole system' approach involving key front line practitioners who worked with the family in a Learning Event held in June 2016. Every effort was made to ensure that Baby LF's 'story' was central to the Learning Event.

Independence

25. An independent chair, Debbie Ross, was appointed by the Local Safeguarding Children Board to chair the Expert Leads Panel. Debbie Ross has been the Chair of Lancashire Safeguarding Children's Board Serious Case Review group since April 2016. Her substantive role is Head of Safeguarding Children at East Lancashire Clinical Commissioning Group. This role incorporates the Designated Nurse functions for Safeguarding and Looked after Children (LAC). She currently co - chairs the NHSE National LAC sub group which sets the health priorities for LAC at a national level.
26. This is her first SCR panel chairing role using the Welsh Model methodology.
27. The Lead Reviewer was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.
28. Ms Hyde is currently working with Local Safeguarding Children Boards and their partners to improve safeguarding outcomes for children and young people living with domestic abuse, substance misuse and parental mental illness and to support the development of a multi-agency response to children and young people at risk of sexual exploitation.
29. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair of several SCRs and a Domestic Homicide Review and has designed and led several Learning Reviews on behalf of Local Safeguarding Children and Adults Boards.

Expert Leads Panel

30. The Expert Leads Panel met on a number of occasions between April 2016 and August 2016. The overview report was ratified at the Local Safeguarding Children Board meeting on 11th October 2016.

31. The Panel comprised of:

32.

Designation	Organisation
Clare Hyde - Independent	Independent Reviewer
East Lancashire CCG Designated Nurse	Independent Chair
Review Officer	Lancashire Constabulary
Named Nurse	Blackpool Teaching Hospital NHS Foundation Trust
Named GP for Safeguarding	Named GP for Safeguarding
Named Professional Safeguarding Children and Primary Care	Fylde and Wyre CCG
Senior Practitioner (Safeguarding Lead)	Marie Stopes

Confidentiality

33. Working Together to Safeguard Children 2015 clearly sets out a requirement for the publication in full of the overview report from SCRs:

34. "All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report may be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."

Family involvement

35. The Lead Reviewer met with MBLF in June 2016 in order to gain her understanding of the events which led to the concealment of her pregnancy and to seek her view on services she had accessed and what, if anything, could have made a difference to her and Baby LF. Her comments are reflected within this report.
36. GFBLF was also invited to contribute to the SCR however he declined the invitation.
37. It was not possible to contact GMBLF.
38. The Lead Reviewer has offered to meet again with MBLF to provide her with the opportunity to see a copy of the report when completed and agreed by the Lancashire Safeguarding Children Board.

Staff involvement

39. The staff who were involved with MBLF and her family participated in a Learning Event in June 2016. The Learning Event was attended by 9 professionals who had had direct involvement with MBLF and her family, in addition to the Lead Reviewer who facilitated the event, the Chair of the SCR Panel and a minute taker. The Learning Event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and minutes were recorded of the event. One crucial agency (the termination of pregnancy service) was not represented at the Learning Event and at this stage had not submitted a chronology or attended the SCR Panel Meetings up to June 2016. Whilst this limited discussion somewhat at the Learning Event and at 2 of the SCR panel meetings the service did provide a chronology in July 2016 detailing the two occasions on which they had contact with MBLF and a representative did attend the third SCR panel meeting to contribute to discussions and agree recommendations.

40. Following the Learning Event, the Lead Reviewer collated the outputs from the Learning Event and from the agency chronologies and began her analysis. In reviewing the findings, the panel gave consideration to what could be done differently to further improve future practice.

Race, Religion, Language and Culture

41. Baby LF's family were English White British. Religion (Christianity) is a considerable feature of their lives. GFBLF had significant social standing within the small rural community in which the family lived.

Family history

42. There was limited information available of the early history of MBLF or her parents. MBLF had one episode of direct contact with the police when she went missing from home at the age of 18 however she and her family had no contact with social services and she was unknown to all services beyond universal service provision up until the time she presented for a termination of pregnancy.
43. The picture that emerged from the accounts of practitioners who had direct contact with MBLF and her parents together with the limited information available from agency records is one of an unusual and complex family.
44. Because of his occupation GFBLF was a uniquely authoritative and respected member of the small rural community where the family lived and worked. On the surface the family were at the heart of a supportive community network. In her discussion with the Lead Reviewer MBLF reported that she had a group of friends with whom she occasionally socialised away from her family. MBLF also reported that she had not confided in any of her friends about the pregnancy.

45. Following the death of Baby LF; GMBLF disclosed that she had been the victim of domestic abuse throughout the 30 plus years of her marriage to GFBLF and following this disclosure MBLF also stated that she had been physically abused by her father and controlled by both parents. This control appears to have been extreme and included financial control.
46. GFBLF and GMBLF separated December 2014 and MBLF initially lived with her mother. She returned briefly to live with her father but is now living independently and receiving support from an Independent Domestic Violence Advisor and the wider community.
47. MBLF has one older sibling who died in January 2016 from an illness.
48. MBLF went missing from home in 2004 at the age of 18. She lived with a man whom she had met over the internet for 2 weeks before returning home to her parents.
49. In conversation with the Lead Reviewer MBLF described that she was too frightened to tell her parents that she was pregnant and told no professionals other than her GP and the termination of pregnancy service that she was pregnant. On other occasions MBLF stated that she told her sibling that she was pregnant but her sibling denied that this was the case. By her own account once MBLF was told that it was too late for her to have a termination of pregnancy she considered taking her own life but then 'buried her head in the sand' and appeared to enter a state of denial.
50. MBLF went into labour on 25th November 2014 and delivered Baby LF in the family bathroom.
51. What happened immediately following Baby LF's birth is not clear and MBLF's account conflicted with GFBLF's account (he was at the family home as Baby LF was born). Furthermore MBLF's account of what happened during and immediately after the baby's birth changed several times during the months that followed.
52. What is clear from agency records is that GFBLF telephoned the police just before 6pm on 25th November to say that his daughter had given birth to a stillborn baby. GFBLF then took MBLF to her GP's surgery leaving Baby LF at the family home.

Overview of the integrated chronology of events and agency involvement

53. This section does not reproduce the full integrated chronology, but highlights the significant practice events which occurred prior to Baby LF's birth and death.
54. Although the timeframe for this SCR was 25th November 2012 to 25th November 2014 agency records held historical information which is relevant to the case and this has been included.

Summary of the Integrated Chronology

55. The integrated Chronology has provided an overview of agency involvement with MBLF between October 2004 and May 2016.
56. One agency record from January 1996 was also considered and this was an Educational Psychologists assessment of MBLF which concluded that MBLF required specific support and activity to improve her confidence and self-esteem. MBLF was 9 years old at the time.
57. MBLF was reported as missing by GMBLF on 26th October 2004. MBLF was 18 years old and her mother told police that she had gone missing from home on one previous occasion the week before. The police conducted missing from home enquiries and it became apparent that MBLF had spoken to her sister and colleagues during this period. The only concern raised was by her colleagues/employers who stated that in their opinion MBLF was vulnerable as she had the presented as younger than her actual age.
58. In November 2004 when MBLF was 18 she attended her family GP. MBLF told her GP that she had argued with her parents after she had lost her jobs and had run away from home but had now returned.

59. The GP observed that MBLF was not confident and perhaps unsuited to the jobs she had tried which MBLF agreed with. MBLF said that she had few friends in the area. The GP also noted that there were no obvious signs of mental illness.

60. It was also noted that MBLF attended this consultation with her mother and came at the recommendation of her last employer but there is no record of why this was the case.

61. Between April 2005 and June 2011 (aged 19 up to 25 years old) MBLF attended her GP practice on 8 occasions for consultations about contraception. On 5 of these occasions MBLF presented as confused about the directions for taking her contraception and said that she often forgot to take her contraceptive pill. On 2 occasions MBLF had taken a pregnancy test which were both negative.

62. MBLF made a visit to a GP on 1st August 2014 when she would have been approximately 6 months pregnant. This visit was in respect of a minor condition.

63. MBLF then visited a GP on 18th August 2014 to request a termination of pregnancy. MBLF told the GP that she had taken a pregnancy test the day before and that she did not know how many weeks pregnant she was. The GP examined MBLF but was unable to ascertain the duration of the pregnancy. The GP made a referral to the termination of pregnancy service.

64. On 20th August 2014 MBLF returned to the GP practice and saw a different GP. She asked for a supply of the contraceptive pill to take following her termination of pregnancy.

65. On 31st August 2014 MBLF attended the termination of pregnancy service and was scanned for gestation of pregnancy and found to be *35 weeks**. MBLF was advised that the termination of pregnancy could not proceed due to legal reasons and was advised to attend her GP for antennal care. No concerns were recorded by the termination of pregnancy service. *On reviewing the ultra sound scan report however; the panel member representing the termination of pregnancy service confirmed that the scan had been of poor quality and that it was not possible to say how many weeks pregnant MBLF was on 31st August. As MBLF

gave birth 12 weeks later and Baby LF was judged to be full term i.e. 40 weeks meaning that MBLF would have been 28 weeks pregnant at 31st August 2015.

66. On 5th September 2014 MBLF visited a different GP for a common health issue. The pregnancy / termination was not discussed.
67. Just before 6pm on 25th November 2014 GFBLF telephoned Lancashire Police stating that his daughter had given birth to a still born baby at their home. The mother indicated that she had tried to abort the baby on several occasions during August 2014. The baby was pronounced dead at the scene and taken by paramedics to Blackpool Teaching Hospital NHS Foundation Trust.
68. Also on 25th November 2014 MBLF was taken in the car by GFBLF to the GP surgery. MBLF told the GP that she had lost a baby down the toilet. MBLF stated that she had gone to the termination of pregnancy clinic in August but they declined a termination due to how advanced the pregnancy was.
69. MBLF stated that she did not come back to see anyone i.e. a GP and had tried to ignore the situation and not told her parents. She stated that she had delivered the baby down the toilet and that her father saw her putting something into the bin and went to investigate and found the dead baby with the umbilical cord around his neck.
70. At this point MBLF was still in pain and bleeding and was uncertain if she had delivered the placenta.
71. The GP asked MBLF's permission to get her father from the car park where he had remained sitting in his car and he came and helped with history of what had happened.
72. GFBLF confirmed that the baby was still at home. The GP advised GFBLF to get the baby and take both MBLF and the baby to the delivery suite at the maternity unit.
73. There are several further agency records which concern the actions taken by health agencies and police in respect of Baby LF's death but these are not relevant to the scope of this SCR.

74. The next piece of agency information which is relevant to this SCR however is a record dated 16th December 2014 made by the Dioceses Safeguarding Adviser which states that the Diocese were informed that GFBLF had been arrested and bailed with conditions not to contact GMBLF or MBLF. This record also states that GMBLF and MBLF have been subject to years of physical and emotional abuse at the hands of GFBLF.
75. A further Dioceses Safeguarding Adviser record dated 22nd December 2014 states that information shared by members of the community that MBLF had disclosed to a former employer that she, her sister and mother had been subject to violence for years by their father (GFBLF).

Analysis

76. During the course of this SCR it became apparent that MBLF has complex and poorly understood vulnerabilities. Her problems with comprehension which were identified when she was aged 9 were not assessed as significant however they do not appear to have been re-assessed since then. These difficulties may have been compounded by a life time of both witnessing domestic abuse and of being a victim of physical abuse and extreme control herself.
77. The impact of this on MBLF's ability to make rational choices and decisions is not understood but what we do know from her own accounts is that her fear of her parent's reaction to her pregnancy was the overriding and overwhelming factor driving the choices and decisions she did make.
78. Throughout her life there were undoubtedly opportunities for members of her close knit rural community to have identified that all was not well with MBLF and her family. Following Baby LF's death and the separation of the family several members of the community reported to the Diocese Safeguarding Adviser that they had been aware of what they described as the 'low level' bullying of MBLF and GMBLF by GFBLF. This tolerance by the

community of what was in fact severe domestic abuse (and child abuse as MBLF was growing up) has implications for the Church of England's safeguarding practice and is reflected in the recommendations in this report.

79. MBLF's employers on at least one occasion had concerns that MBLF's possible cognitive difficulties were significant and it was upon one employer's advice that she visited her GP.
80. These missed opportunities to identify that domestic abuse was occurring meant that at the age of 29 when she became pregnant MBLF was still living with her parents in a household where control and abuse affected her daily life.
81. Prior to Baby LF's conception, MBLF visited the GP practice for routine contraception advice and although she struggled to understand and follow the instructions for taking the contraceptives the GP reports that this is not entirely unusual. MBLF's other, infrequent, visits to her GP were for routine and minor illnesses.
82. MBLF's visit to the termination of pregnancy service represented the most significant missed opportunity during the timescale of this review. MBLF attended the service having been referred by her GP. MBLF was scanned for gestation of pregnancy and found by the termination of pregnancy to be 35* weeks pregnant and therefore unable to proceed with treatment due to legal reasons. No concerns were noted by the practitioner and MBLF was advised to attend her GP for antenatal care. * please see paragraph 65 above
83. This was a missed opportunity to enquire why MBLF had presented so late into her pregnancy for a termination and given her vulnerabilities to consider a safeguarding response for both MBLF and her unborn baby.

The SCR Terms of Reference: Analysis

84. In relation to the pregnancy what was known amongst agencies and how was this shared within the multi-agency arena?

85. MBLF was a 28 year old adult when she sought advice from her GP about a termination of pregnancy. Her GP was unable to ascertain the length of the pregnancy due to MBLF's body shape and he referred her to a termination of pregnancy service. (In discussion with the Lead Reviewer MBLF mentioned that this GP was a male and did not speak English very clearly. MBLF felt that this made it more difficult for her to talk to the GP and to be understood by him). MBLF's vulnerabilities were not recognised by any GP within the GP practice because the circumstances of her home life were not known therefore this consultation did not trigger safeguarding concerns for MBLF or Baby LF.

86. The termination of pregnancy service did not share information about MBLF's visit to their service with the GP who made the referral. In view of the fact that MBLF had presented so late into her pregnancy this should have prompted an immediate sharing of information as the connection between late presentation in pregnancy and poorer outcomes for babies and their mothers is well known.

87. A key theme across the limited agency intervention was MBLF's presentation as a woman with some form of learning or cognitive difficulty. However she did not present as needing specialist support beyond universal service provision. Throughout MBLF's limited contact with services, there were only two occasions where any joint agency working was possible one was between the police and other agencies when MBLF went missing from home and the second between the termination of pregnancy service and the GP and both of these occasions are described above.

88. In summary there was no multi-agency sharing of information in this case.

89. Is there any understanding within the information known to agencies that would help agencies to understand the reasons why women choose to conceal pregnancies?

90. The agency which was best placed to understand why women choose to conceal pregnancies was the termination of pregnancy service which, by its very nature, is delivering

a service to women who make a choice not to continue with a pregnancy. Such a late presentation would and should have triggered particular concern.

91. The research which does exist which will help to further agency understanding of why women conceal pregnancy was shared with practitioners who participated in the Learning Event and this, together with learning specific to this review, will be shared more widely as a recommendation of this report.

92. Is the board assured that the process of information sharing between Termination of Pregnancy provider organisation and GP's is robust particularly if a termination of pregnancy cannot be performed?

93. In this case there was no sharing of information between the termination of pregnancy service and the referring GP or maternity services and a recommendation has been made at paragraph 105 of this report to ensure immediate action is taken to put information sharing arrangements in place.

94. What does national and international research tell us about women with lifelong exposure to abuse and concealed pregnancy?

95. Research and studies show that women who conceal or deny a pregnancy include those who experience domestic violence, rape and incest (Spielvogel & Hohener 1995, Friedman et al. 2007, Porter & Gavin 2010).

96. In addition, Thynne et al. (2012) reported that fear of family reaction to a pregnancy was a reality for women of various ages.

97. Psychiatric disorders, such as schizophrenia, and depression, have been reported to contribute to denial and concealment of pregnancy. Because MBLF's mental health was not assessed before or after Baby LF's birth it is not possible to say that she did have mental health difficulties but her history of abuse and extreme control may mean that there will have been an impact on her mental health.

98. MBLF's profile and her behaviour reflect some of the key messages extracted from the literature/research reviewed, in particular, the challenge for agencies in predicting and identifying concealed/denied pregnancies.

99. In their study of more than 30,000 birth records at a Midwestern urban hospital, Susan Hatters Friedman, M.D., of Case Western Reserve University, and colleagues found that pregnancy denial and concealment is relatively rare, occurring in only 0.26 percent of all deliveries. However, fewer than 5 percent — four of 81 of these mothers — received psychiatric referrals, "although infants were frequently discharged to the care of mothers who had denied or concealed their existence until birth,"

    Friedman said health-care workers seem to be "relatively insensitive" to seeing these unusual pregnancies as a possible trigger for psychiatric evaluations. The small number of referrals may "indicate an important missed opportunity for psychiatric intervention".

100. In MBLF's case the nature and extent of a possible cognitive difficulty and a lifetime's experience of trauma, abuse and control were not known during the ante natal period nor in the immediate hours and days following Baby LF's birth and death.

Summary

101. In summary, the concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and well-being of the 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 co-ordinating 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.

N.B. This SCR was taking place concurrently with a second SCR which also involved the death of a baby following a concealed pregnancy. Some of the recommendations are relevant to both SCRs and this will be taken into account in action / improvement/ learning plans.

Multi Agency Recommendations

102. The LSCB should consider implementing a Concealed and Denied Pregnancy Protocol which reflects current best practice (such as the Greater Manchester Safeguarding Partnership's guidance) within 3 months of publication of this SCR**.**

103. It is recommended that partners share the learning from this review with practitioners who come into contact with women and girls of childbearing age with the specific aim of alerting them to risks associated with concealed or denied pregnancy and to promote the Concealed and Denied Pregnancy Protocol (see 102 above) within 6 months of the implementation of the protocol.

104. All NHS commissioners of Termination of Pregnancy services to ensure that services are fit for purpose and appropriate safeguarding measures are in place e.g. late presentations, completing appropriate risk assessments, recording of who attends with women/ girls accessing services, child sexual exploitation screening, domestic abuse screening.

105. In addition; a multi -agency pathway should be established as a matter of urgency between GPs, maternity services and termination of pregnancy services which recognises that late presentation for a termination of pregnancy (>24 weeks) maybe a safeguarding concern dependent on the circumstances and should trigger sharing of information and a referral to children's social care if necessary.

106. The pathway should include consideration of referral to other services e.g. domestic abuse services, vulnerable adult services, children's social care, substance misuse services, mental health services to allow sensitive exploration of needs and risk assessment.

107. Partners should develop guidance for staff who may come into contact with women or family members following the death of a baby where there has been concealed or denied pregnancy and the cause of death has not been ascertained. This guidance should give clear direction to staff to ensure that evidence (including witness accounts) are not compromised.

108. Partners should ensure that internal policies/ procedures adequately support and guide staff not only in respect of how staff deal with this rare but significant event but how staff cope with the impact that this may have upon them as individuals.

Single Agency Learning

Diocese of Blackburn

109. The Diocese should highlight within training of the clergy, parish, volunteers and laity the importance of information sharing regarding any safeguarding concerns.

110. The Diocese should highlight the role of the Diocesan Safeguarding Adviser when the safeguarding concerns relate to the Clergy, Clergy's spouse and family

111. The Diocese should consider developing a 'listening' service for those who feel unable to approach the Diocese Safeguarding Adviser

112. Using the learning from this SCR The Diocese should undertake a 'core group' review of the church practice and learning points and raise concerns with National Church where appropriate

113. The Diocese should raise the profile of the church with police and statutory agencies to ensure that they are included in safeguarding processes.

114. The learning from this SCR should be shared with other Diocese Safeguarding Advisors as a learning opportunity

Termination of Pregnancy Service

115. Using the learning from this SCR the termination of pregnancy service should review its quality assurance processes in respect of ultra sound scans particularly when women or girls requesting terminations are over 20 weeks gestation.

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