Child Safeguarding Practice Review

Overview Report: Child AF

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1. Introduction

1.1 This review concerns Child AF and her mother Sophie. Child AF was born at approximately 24 weeks gestation following her mother attending her local delivery suite after going into early labour. Child AF sadly died at one day old, her prematurity being such that her survival prospects were poor from birth. This was Sophie's sixth pregnancy, her other children and Child AF's siblings did not reside in her care due to concerns that they would be at risk of significant harm if Sophie were to care for them.

1.2 Sophie herself had experienced a difficult and traumatic childhood, including being exposed to neglectful parenting from her caregivers, exposure to parental alcohol abuse and domestic abuse from her mother's partner to her mother. During the care proceedings in respect of Child AF's siblings, Sophie underwent a psychological assessment which was indicative that Sophie had Autistic Spectrum Disorder or ASD. At the time of the most recent care proceedings, Sophie found it difficult to engage in activities of daily living during the daytime and was described to have high functioning autism with reported Obsessive Compulsive Disorder (OCD) traits.

1.3 The reasons that professionals were concerned as to Sophie's ability to care for her children were due to a number of issues including Sophie's mental health, the use of illicit substances namely amphetamine, sexual abuse and neglect. Children's Social Care were also worried that Sophie didn't engage with services especially where there were concerns about her ability to care for her children.

1.4 Sophie was known to Lancashire Constabulary with over 80 incidents and/or investigations recorded on their systems involving her both as a victim, suspect and third party. These spanned and are not limited to assaults, harassment, domestic abuse and damage cases. Her case had been previously heard at 'MARAC' due to the significant concerns regarding her vulnerabilities and incidents concerning her as a victim of domestic abuse.

1.5 Sophie's pregnancy with Child AF became known to Lancashire Constabulary following a vehicle pursuit in which Sophie was found nearby after the vehicle had been abandoned and she had made off with a male on foot. Sophie was arrested and disclosed to officers that she was eight weeks pregnant. An appointment was made for her to attend the Early Pregnancy Unit and this led to a referral being made to Children's Social Care which wasn't accepted due to the pregnancy being unconfirmed by health services.

1.6 Sophie chose to have a Termination of Pregnancy at approximately 10 weeks gestation, however Sophie did not complete the termination procedure. The pregnancy of Child AF was concealed by Sophie in an attempt to prevent Children's Social Care from removing the baby

from her. A family member raised concerns on two occasions to Children's Social Care that Sophie was concealing her pregnancy. The first report resulted in a pre-birth assessment being commenced which was closed and uncompleted due to professionals accepting Sophie's self-reporting that she had terminated the pregnancy. The second report by the family member led to further enquiries being undertaken by Children's Social Care however, three days later Sophie presented to the Delivery Suite in labour.

1.7 It is not known how Sophie came to be in early labour with Child AF at 24 weeks gestation. Health professionals suspect that Sophie may have gone into early labour following taking misoprostol, a medication used in terminations and which Sophie had been given following her attendance at the clinic for the termination. Sophie denied having taken misoprostol however, doctors found hexagonal shaped tablets indicative of this medicine within her ruptured membranes and believe she was trying to conceal the presence of the tablets. The presence of this substance cannot be confirmed as the tablets were disposed of after delivery. If indeed Sophie did take misoprostol, it is unknown why she did so.

2. Terms of Reference

2.1 The timeframe of the review is from 18th February 2021 to 8th August 201. This time-period has been set to encompass the time-period between the first indication that Sophie was pregnant with Child AF until her delivery and date of death. Any significant incident which occurred prior to, or following this timeline will also be included.

2.2 Key time-periods were identified during the review process. These are periods which are deemed to be central to the understanding of Sophie's pregnancy. These time-periods do not form a complete history but they were recognised as being important periods for the review to focus upon. Professionals at the panel meetings explored the following key time-periods with the Chair and the Reviewer:

Key Time-Period
Sophie's disclosure to Lancashire Police that she was pregnant
Sophie's non-attendance at the Early Pregnancy Assessment Unit
Sophie's first appointment for the termination of the pregnancy
Referral into Children's Social Care from the Early Pregnancy Assessment Unit
Process of confirming whether the pregnancy had been terminated
MASH referral
Closure of the Pre Birth Assessment

2.3 The terms of reference for the review were agreed as:

a) Consideration of the effectiveness of safeguarding practices across agencies.

b) Examination of the circumstances around Mum being send home with the second tablet, as part of the early medical termination procedure.

c) Examination of the processes for vulnerable expectant mothers and the use of the second pill.

d) Consideration of whether there is a link between concealed pregnancy and the second part of early medical termination.

e) Consideration of how appropriate care and support given was following the first stage of early medical termination in this case.

f) Did Covid-19 restrictions at the time of death have any impact on the single or multi-agency response in this case?

3. Methodology

3.1 The review used a combined method of the traditional review model together with elements of the Welsh concise model[1] and incorporated chronologies together with focused agency reports which provided agencies with an opportunity to analyse their own involvement in the case and to reflect upon their own agency's learning. Strong emphasis was placed the engagement of front-line practitioners and managers by way of a Learning Event which provided the opportunity for inter-agency discussion and learning.

3.2 Panel Members completed timelines and chronologies, which described and analysed their involvement with Sophie. The Reviewer analysed the chronologies and identified issues and key episodes to explore with the front-line practitioners who attended the Practitioner Learning Event.

3.3 The Practitioner Learning Event was well attended by front line practitioners who worked with Sophie. The event enabled all participants to discuss and critically analyse the key episodes identified. The agencies in attendance contributed to the learning identified within the review and also identified strengths and good practice within the timeline that was considered.

3.4 Family involvement in a Child Safeguarding Practice Review is an important part of the review process. The Safeguarding Partnership attempted to contact both Sophie and her mother to notify them of the review and to invite them to participate in the review process. Unfortunately, the Safeguarding Partnership were unable to make contact with Sophie or members of her family and therefore their experiences were not able to directly be able to

[1] Bright C (2015) Review of the implementation of the Child Practice Review Framework. Welsh Government Social Research

be incorporated into review. Although those front line practitioners who worked directly with Sophie were able to assist the review by sharing Sophie's experiences as far as they were able to do so this was limited as few of the practitioners had established working relationships with her.

4. Analysis

4.1 Understanding of Termination of Pregnancy Procedures

The review considered the understanding of Children Social Care staff of Termination of Pregnancy Procedures and found that there was a lack of understanding across Children's Social Care staff as to how pregnancies are terminated, the different methods and local procedures. As such it was recognised at the Practitioner Learning Event that training on what constituted a terminated pregnancy was needed. The review also considered whether there may have been gender bias as the social worker who was allocated the pre-birth assessment was a male social worker. The review has found that there was no gender bias from the allocated pre-birth social worker as the lack of understanding was found to be across Children's Social Care staff regardless of gender.

In this case, the lack of understanding of the procedure, caused confusion and assumptions to be made as to whether Sophie had terminated the pregnancy. This is simply due to a lack of knowledge and understanding. East Lancashire Hospitals NHS Trust have offered to provide this training to Children's Social Care staff which the Specialist Perinatal Mental Health Service have also agreed that this would also be useful training for them to attend. Such training would give all professionals working in the area of pre-birth assessments and support services for those women who are pregnant and considering termination, thus strengthening safeguarding practices across the area for those who are working in the area of pre-birth safeguarding assessments.

Practically, there was lots of communication between Children's Social Care and the Early Pregnancy Unit but the quality of information being shared could have been improved and Children's Social Care could have made more use of safeguarding leads at East Lancashire Hospitals NHS Trust who had the knowledge and understanding in respect of the procedure.

Within the East Lancashire Hospitals NHS Trust area termination procedures are offered and undertaken in line with NICE Guidelines[2]. They include the patient initially attending the termination clinic and being provided with information and a discussion about the procedure. The patient then returns to the clinic to complete the first stage of the procedure which is the taking of a tablet in the clinic. In cases of early medical termination, (up to 10 weeks of pregnancy), woman can take medication home to complete the termination procedure. The fact that the procedure is completed in stages was not understood by Children Social Care

[2] NICE Guidance NG140 Abortion Care (2019) and Department of Health Guidance (2018)

professionals and as such when they telephoned and spoke to a midwife who confirmed that Sophie had attended the clinic for the procedure, their assumption was that the termination had been completed. In fact, the midwife providing that information over the phone was correct in that Sophie had attended the clinic. She was unable to confirm whether Sophie remained pregnant as the further stages of the procedure are that the patient is sent home with tablets to take at home, stages that Sophie could only confirm that she had completed. This was not known to Children's Social Care staff.

The siblings' social worker sought confirmation from midwifery whether Sophie remained pregnant and received an email to confirm that the procedure was completed in clinic. The midwifery service set out within that email that the mother was sent home with tablets to be taken/inserted. That information was not understood by the social worker and the pregnancy was recorded by Children's Social Care as being terminated. No consideration was given to the potential scenario that Sophie may not have completed the procedure at home because of a lack of understanding of the procedure.

The further stages of the procedure are that four tablets are provided to be inserted by the patient at home vaginally 48 hours after attending the clinic and a further tablet to be taken a week later. All that midwives could tell Children's Social Care professionals over the telephone was that Sophie had taken a tablet in clinic not that she had terminated the pregnancy. This could have been communicated clearer and earlier to Children's Social Care staff when they contacted midwifery. Midwifery could have considered that Children's Social Care staff may not have had the same level of knowledge and understanding of the procedure as they did as health professionals but did not do so. It would seem that language was simplified to questions around whether Sophie had attended the clinic for termination and whether the procedure had been completed in clinic on that day.

Clearer communication together with an understanding of the termination procedure would have meant that Children's Social Care would have known much earlier than they did that the termination could not be confirmed and that there was a possibility that Sophie could still be pregnant. The lack of understanding meant that this information was not quickly understood by Children's Social Care and delayed the commencement of a pre birth assessment.

4.2 <u>Communication</u>

a) Communication within Children's Social Care

Sophie was known to different professionals within Children's Social Care who throughout her pregnancy with Child AF communicated well with each other. Those included the allocated social worker to the siblings, contact supervisors and the allocated social worker responsible allocated the pre-birth assessment. In particular, the allocated social worker to the siblings took concerns that Sophie may be pregnant and reports that Sophie may still be pregnant to other professionals within Children's Social Care.

At the time of the initial referral to Children's Social Care, referrals were only accepted if the pregnancy had been confirmed by health services and there was an estimated due date (EDD). As the pregnancy was not confirmed and only self-reported by Sophie the referral was not accepted. There was also a presumption that the sibling's social worker would be able to make the necessary referral as and when the pregnancy was confirmed. This approach led to a delay in instigating safeguarding measures for the unborn baby and taken together with a woman who was not going to book in for antenatal care would as a policy have meant that opportunities for early assessment were missed. It is unknown why Children's Social Care had such a policy not to accept referrals of unconfirmed pregnancies. Indeed, it may be the case that pregnancies that are unconfirmed because of an intention to conceal or deny are the very cases that require early allocation and assessment.

Since the death of Child AF, Children's Social Care have changed their policy in respect of how they accept and allocate referrals made in cases of suspected pregnancies where there are safeguarding concerns. There is now full consideration of each case by the MASH team. This will ensure that cases are accepted sooner and allocated to a social worker for pre-birth assessment. This will also prevent the situation of a mother not being assessed if she fails to book in for antenatal care or presents late to midwifery services.

b) Communication Between Health and Children's Social Care

There were numerous examples of contact between Health and Children's Social Care at both the early stages of pregnancy and when agencies became concerned that Sophie remained pregnant. Many of those contacts were to the Early Pregnancy Unit who provided information by telephone as discussed above. The review found that there were opportunities for both agencies to improve their communications with each other. The learning point in respect of Children's Social Care understanding of termination procedures is discussed above and in conjunction with that is a general need to bring together the skills of both Children's Social Care and Health when safeguarding cases involving pregnancies in the early stages which haven't been booked in and where woman consider terminating pregnancies.

Within the Termination Clinic there was reference to gynaecology referring Sophie to safeguarding regardless of whether she decided to terminate the pregnancy or not after her initial appointment. Sophie was however, not referred to Children's Social Care at this point and should have been. Had this happened, it would have given Children's Social Care the opportunity to be made aware of the recent contact with the clinic by Sophie and concerns of the gynaecology staff. Whilst at the time, this is likely to have resulted in an accepted referral as this would have at the time have been classed as a confirmed pregnancy by health services. Given Sophie's history of Children's Social Care involvement, this would have resulted in an earlier allocation for a pre- birth assessment.

When Sophie returned to the clinic 5 days later for the first part of the procedure, gynaecology contacted their own safeguarding team regarding the first part of the termination procedure but neither safeguarding nor gynaecology liaised with Children's Social Care at this point. This should have been done for the reasons set out above to share information in respect of Sophie given her history and previous Children's Social Care involvement. Given the policy of accepting referrals at the time of this case, it is unlikely that Children's Social Care would have accepted any referral that was made after the termination procedure had commenced but it may have alerted them to the fact that the termination procedure was carried out in stages and that gynaecology could not confirm whether Sophie remained pregnant. There was certainly an opportunity here for that information to be shared.

c) Communication with Sophie and her Family

There was a good relationship between Children's Social Care and Sophie's mother who felt able to share her concerns with the sibling's social worker that Sophie remained pregnant after the termination procedure. Information from Sophie's mother was that Sophie had been attending private scans and was planning to present in another area and using the name of her sister as an alias to avoid Children's Social Care intervention. This was appropriately passed from the sibling's social worker to the MASH team who made the decision that a pre-birth assessment was necessary given the information received. This was also the first opportunity to consider a strategy meeting under the Pan Lancashire Concealed and Denied Pregnancy Guidance given the detailed information provided by Sophie's mother that Sophie was concealing her pregnancy. This would have allowed all agencies to come together to consider the safeguarding plan for Child AF. Had a multi-agency discussion been held at this point, it would have been apparent to Children's Social Care, through discussions with health at the meeting, that there was a possibility that Sophie had not completed the termination procedure at home and that she may still be pregnant. That together with the information provided by Sophie's mother would have been a strong indication that Sophie may have been concealing her pregnancy.

The social worker allocated to undertake the pre-birth assessment carried out an unannounced visit when Sophie was not at home. They observed a pram through the window and a toy car in its packaging in the front room. Phone calls to Sophie went unanswered and a note was left for her to call the social worker when she returned home. Surprisingly, given her ASD diagnosis, Sophie telephoned the social worker and engaged by telephone and arrangements were made for the social worker to visit Sophie.

During that visit, Sophie insisted that she was not pregnant and that she had had a termination. She offered to take pregnancy tests at home to prove that she wasn't pregnant whilst the social worker was at her home and attended Children's Social Care offices the next day with a negative test.

There was an over-reliance placed on Sophie's story and an acceptance that the tests being shown were accurate. The social worker, not understanding the termination procedure, had no reason to challenge her assertion that the hospital had watched her take the tablets in the clinic. There were, however, opportunities to ask Sophie to take a pregnancy test in line with the Pan Lancashire Concealed and Denied Pregnancy Guidance rather than show staff one that she had brought with her and opportunities to challenge Sophie on the pram observed in the house. Sophie was not challenged directly on the suggestion made by her mother that she was concealing the pregnancy and had been to have private scans. There was also an over-reliance on Sophie not appearing to be visibly pregnant. The pre-birth assessment was ceased and not completed because it was accepted that Sophie had terminated the pregnancy. No multi-agency strategy meeting was convened, despite the fact that a family member had provided information that Sophie was concealing her pregnancy.

Two weeks after the pre-birth assessment was closed, Sophie's mother contacted Children's Social Care with evidence that Sophie had been to a private clinic for scans and provided information that Sophie was using an alias at scan appointments and using laxatives to stay slim and hide her pregnancy. At the same time the sibling's social worker also becomes concerned that the mother is showing with a bump. The referral was passed to the MASH team to process which it was but given the history and the concerns, the case should have been immediately re-opened with an urgent multi-agency strategy meeting convened as a suspected concealed pregnancy. Again, the focus was on whether there was a confirmed pregnancy with Health rather than the suspected concealed pregnancy in itself being reason for a multi-agency strategy meeting. It may have been the case that Children's Social Care would have proceeded to convene a multi-agency strategy meeting however, Sophie presented to the Delivery Suite, in labour, three days after Sophie's mother called with her further concerns.

The review did not find that Covid-19 and measures brought in by the pandemic impacted this case in any way.

d) Communication with Primary Care

Since 2019, the East Lancashire Hospitals NHS Trust have not notified GPs within Primary Care when a woman attends for a termination procedure. They cite examples where locally there have been issues with confidential information regarding a termination procedure being disclosed by an employee known to a patient in a GP surgery. This is of enormous concern given the sensitivity which can be felt around terminations and the potential danger for women who may be suffering domestic abuse or who may have family members who hold strong views of terminations. The decision by East Lancashire Hospitals NHS Trust to amend its data-sharing practice following a reported data breach is not a proportionate response and may hinder appropriate information sharing.

Patients have a right to confidentiality and there is no requirement to notify GPs that a woman has attended for a termination procedure. Some hospitals and clinics translate this into a policy of not informing GPs and not offering women the option to inform their GP as in the case of hospital trusts within this particular safeguarding partnership's area. There are examples of hospital trusts and clinics where GPs are informed of termination procedures with the patient's consent in order to provide appropriate aftercare. All health information is important for GPs to know as front line and primary care medical practitioners. Given the rare complications, such as sepsis, that can arise following early medication terminations, GPs would want to know all relevant health information when seeing patients in primary care settings as in cases of becoming unwell, it is likely that patients would present to their GP. In order to appropriately care and treat patients, a full medical history including information concerning recent procedures is necessary.

Information regarding terminations should be shared with GPs, with patients' consent, and patients should always be given the opportunity to consent to information sharing with their GP to inform any aftercare issues. There will be cases where women have reasons for not sharing information with their GP and in those cases, this should be discussed with the patient and confidentiality respected.

In those cases where there are safeguarding concerns, GPs should always be informed of termination procedures as part of a multi agency response and care plan to inform safeguarding in the same way that Children's Social Care are.

4.3 <u>Identification of Vunerabilities</u>

a) Learning Disabilities

i) Sophie had been diagnosed with Autistic Spectrum Disorder as part of the pre-proceedings process in 2020 and in respect of her fifth pregnancy. Sophie was assessed with high functioning autism and this may have meant that Sophie did not display ASD traits which were recognised by professionals working with her. Notwithstanding that, this was a diagnosis which was only made in 2020 despite there having been lengthy professional involvement in Sophie's life and there may have been opportunities to diagnose Sophie earlier in her life. After her diagnosis, Sophie described herself as 'autistic' to professionals that came into contact with her and appeared to be comfortable with providing this information to professionals. During Sophie's fifth pregnancy and as a result of the recent diagnosis, she was referred to and seen by the Specialist Perinatal Community Mental Health Team. At this point in 2020, she was 30 weeks pregnant with her fifth pregnancy and keen to engage with a local ASD service. Those assessing Sophie did not see evidence of a severe and enduring mental health problem at that time but did refer her to a service to provide Sophie with support and understanding around her ASD diagnosis. Ultimately, Sophie did

not engage with support and referrals made in that pregnancy.

ii) There is good evidence that the Police recognised Sophie's diagnosis of ASD when they arrested her following the incident with the stolen car. The decision of the Custody Sargeant to refer Sophie to the Liaison and Diversion Team, given they had a female in custody with a history of mental health issues, substance misuse who was reporting to be eight weeks pregnant was good practice and identified that Sophie was vulnerable. Whilst Sophie declined further support from the Liaison and Diversion Team, they were able to consider Sophie's notes held with Lancashire and South Cumbria Foundation Trust (who provide the mental health services locally) and this gave information to the practitioner in respect of Sophie's history and previous involvement with the mental health service.

iii) It would have been good practice for the practitioner from the Liaison and Diversion Team to either contact Children's Social Care or to suggest to the referring Custody Sargeant that they made a Children's Social Care referral given the information that they had available to them on their systems regarding Sophie's history and given that she was reporting to be eight weeks pregnant.

iv) The Custody Sargeant did share information with the Emergency Duty Team of Childrens Social Care regarding Sophie's current situation however the information was not recorded on Children's Social Care systems until 10 days after Sophie was in custody. It is unknown why there was a delay in receiving this information. However, for reasons set out above, given the policy in place at the time, the contact would not have progressed due to this being an unconfirmed pregnancy report. This was another missed opportunity for Children's Social Care to have early contact with Sophie and to have discussions with her about her plans for the pregnancy. Given her Children's Social Care history and ASD diagnosis, this was an important opportunity to make contact with Sophie and to attempt to engage her.

v) The information regarding Sophie's diagnosis of ASD is embedded within Children's Social Care files having been a part of previous care proceedings, which the local authority brought in respect of the other children. That information is accessible to all those within Children's Social Care who choose to read and indeed have time upon allocation to read the file. It was apparent upon speaking with professionals from Children's Social Care that the information regarding a parents' learning disability is not immediately apparent upon looking at the file concerning that parent. The social worker allocated the pre-birth assessment, would have been assisted in knowing the information regarding Sophie's learning disability, and this was not immediately known to him upon being allocated the case because there is currently no mechanism to flag this information on the case management system. Information regarding a parents' disability, in particular their learning disabilities, are essential to

informing and planning how a worker should engage with a parent in accordance with their needs. If this information is known to the service, it should be flagged in such a way that anybody looking at the file would be immediately aware of this information. In Sophie's case, she was previously assisted by being contacted by text message first to let her know that somebody would be calling her and who that person would be. Children's Social Care should develop a mechanism by which they can record on their system a parent's learning disability. This will inform early identification of tailored and specific support needs and communication strategies for that parent.

b) Vulnerable Cohort

i) The review has considered factors which would mean that a woman who is pregnant should be considered to be vulnerable. NICE has produced guidance titled, 'Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors,[3] which provides guidance for antenatal care for all pregnant woman with complex social factors. The factors listed, although not limited to, are alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20 and domestic abuse.

ii) The recommendations of the guidance are that care providers should consider initiating a multi-agency needs assessment including safeguarding issues so that the woman has a coordinated care plan. This isn't guidance that would have applied to Sophie, she wasn't accessing antenatal care and wasn't booked in for the same. However, the principles that services should identify those pregnant women with complex social factors and tailor services for them are relevant whether that women choses to proceed with the pregnancy and book in for antenatal care or attends a termination clinic.

iii) Whilst there are some factors set out in the Guidance above, many women have complex social factors and vulnerabilities which arise from them. In Sophie's case they included previous Children's Social Care, chaotic lifestyle, learning disabilities (autism diagnosis), mental health issues, drug and/or alcohol use and domestic abuse. The combination of factors in Sophie's case meant that she was vulnerable and services should have been considered with those vulnerabilities in mind.

c) Support offered for those in the Vulnerable Cohort

i) At the time of Sophie's attendance at the termination clinic, Sophie was not offered any enhanced support or care. She had, known previous involvement with Children's Social Care, and this had led to the Early Pregnancy Unit

[3] Clinical Guidance [CG110] Overview | Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors | Guidance | NICE

contacting Children's Social Care who did not initially take on the referral. As a pregnant woman with ASD, Sophie should have also been referred to the Specialist Perinatal Mental Health Team who could have offered her an assessment and support in relation to her autism.

ii) As discussed above, the referral to Children's Social Care was rejected because Sophie had not 'booked in' to midwifery services. At the time of Sophie's pregnancy with Child AF, Children's Social Care only took pre-birth referrals for women who had 'booked in' to midwifery or where there was a confirmed pregnancy. It is not known what the rationale for this policy was. This policy has changed since Sophie's pregnancy and now all referrals are screened. The opportunity to support and engage with Sophie was initially missed by Children's Social Care because of this decision.

iii) No referral to the Specialist Perinatal Mental Health Team was made during this pregnancy because Sophie had elected to have a termination. Had she been progressing openly with the pregnancy, it is likely that the Specialist Perinatal Mental Health Team would have been made aware of Sophie and her ASD diagnosis and could have provided her with appropriate signposting for ASD support in the event that no enduring mental health illness was observed. There was an opportunity to refer Sophie to the Specialist Perinatal Mental Health Team notwithstanding her decision to terminate the pregnancy. She was eligible for the perinatal service because of her ASD diagnosis and pregnancy. Early support from this service would have provided Sophie with an opportunity to discuss with specialist perinatal mental health staff any support that she needed around the termination procedure given her autism diagnosis.

iv) Women who are vulnerable for a variety of factors may not require specialist care and support. It may be appropriate to follow the standard procedures in relation to the termination of pregnancies. However, those women who are within the vulnerable cohort should be provided with the option of enhanced support and care, and this should include the option of an inpatient termination service. It would not be appropriate to be prescriptive as to what level of support and care should be provided and each case will be extremely case specific. Choice for the women choosing to have a termination should remain a central pillar for health services, providing termination procedures, but to those who are identified as being vulnerable should be offered care and support tailored to their individual needs and circumstances.

v) In cases involving women who have had a medical abortion, up to and including 10 weeks gestation, NICE Guidance suggests self-assessment including remote assessment (for example telephone or text messaging) as an alternative to clinic follow up.[4] Whilst all women are provided with safety netting advice and guidance on what to do when they get home. If they are

[4] Overview | Abortion care | Guidance | NICE

concerned, East Lancashire Hospitals NHS Trust do not offer telephone calls or clinic follow up for women post early medical termination procedures due to resource issues. Had Sophie been contacted post procedure in any of the ways outlined in the Guidance, given her history and ASD diagnosis, she is likely not to have engaged with the follow up and it is therefore important that women who are identified as vulnerable are offered follow up as part of the enhanced care and support outlined above.

vi) The identification of factors, which identify a pregnant woman to be vulnerable and the offering of enhanced care and support, has been recognised as a learning point in another review with the Children's Safeguarding Assurance Partnership. The second review does not involve termination services offered by the East Lancashire Hospitals NHS Trust, but the learning points in respect of the identification of a vulnerable cohort of women accessing termination services. The offering of enhanced support and care are the same across both reviews. As such, the Children's Safeguarding Assurance Partnership should consider a Pan-Lancashire discussion and response to support the development of both the identification of the vulnerable cohort. The enhanced support and care should also be offered across termination services in their safeguarding area.

4.4 Consideration of the Pan Lancashire Concealed and Denied Pregnancy Guidance

The Children's Safeguarding Assurance Partnership produced Pan Lancashire Guidance on Concealed and Denied Pregnancy in consultation with their statutory partners. The Guidance provides a clear framework for safeguarding in cases where there is suspected concealed or denied pregnancy and acknowledges the many reasons why a woman may choose to conceal or deny a pregnancy.

The flowchart within that Guidance, provides a visual guide for practitioners, setting out what steps should be taken if a concealed or denied pregnancy is suspected. The Guidance is known to Children's Social Care and Health, both being partners to its discussion and creation. The front-line practitioners who attended the Practitioner Learning Event were aware of its existence but perhaps not the detail contained within it. In particular and in this case, no multi agency strategy meeting was convened when Children's Social Care received reports that Sophie was concealing her pregnancy. The Guidance correctly identifies the importance of early multi agency discussions by way of a strategy meeting to plan for the possibility of a concealed or denied pregnancy. As detailed elsewhere in the review, this would have allowed practitioners from all agencies to meet to discuss the concerns leading to early identification that Sophie may be misleading professionals and concealing her pregnancy.

It is recommended that Children's Social Care revisit this guidance and refamiliarize themselves with the escalation steps within in for cases of concealed pregnancies.

One of the features of this case was a reluctance to ask Sophie to undertake a pregnancy test. As is detailed above, Sophie was happy to show professionals the pregnancy tests given to her at the termination clinic and to attend Children's Social Care offices with negative tests. It is not known how Sophie produced those tests, either by way of asking for a friend's help or placing water on the testing area. In whatever circumstances, Sophie was producing and showing false pregnancy test results to professionals.

Whilst the Concealed and Denied Pregnancy Guidance details that professionals should ask for a pregnancy test to be undertaken, the reality in cases of concealed pregnancy is that it is likely that alongside a woman refusing and thereby giving an indication that she is pregnant, there will be cases, such as in the case of Sophie, where a negative test may be produced by placing water and not urine on the testing pack in the bathroom.

The most certain method of identifying a concealed pregnancy is to invite the women concerned to a scan. The refusal of this appointment will be a clear indicator that the women is likely to be concealing the pregnancy, although not determinative. East Lancashire Hospitals NHS Trust offered within the Practitioner Learning Event to provide ultrasound scans to women in cases where there is a suspected concealed pregnancy.

If offered a scan, Sophie would likely have refused, but this would have given the multi-agency response the ability to plan for a likely concealed pregnancy and take the necessary steps to protect the unborn baby, although the review considers that this may not have changed the outcome for Child AF.

The offer of an ultrasound scan was not something that Children's Social Care consider and in developing their relationship with health and midwifery, this is something that could be developed in partnership between the two partners. Whilst scans are within the Concealed and Denied Pregnancy Guidance and flowchart, they need to be more prominent within the working knowledge of practitioners undertaking enquiries into suspected cases of concealed pregnancies. This would be greatly supported by the early identification of cases where concealed pregnancies may be suspected and early convening of a multi-agency meeting in all cases of suspected concealed pregnancy. This is especially true in the reality that it may be appropriate to send women with vulnerabilities home to complete early termination procedures. In such a landscape, women who wish to conceal pregnancies and avoid Children's Social Care involvement have a greater opportunity to do so.

5. Learning Recommendations

LP1: Children's Social Care and Lancashire and South Cumbria Foundation Trust identified the need for training in the area of Termination of Pregnancy. This training has been offered by health partners to develop the knowledge and understanding of practitioners in both Children's Social Care and Mental Health teams working within safeguarding and with vulnerable expectant mothers. All practitioners across Children's Social Care and Mental Health need to have a good working understanding of Termination of Pregnancy procedures within their local area.

LP2: In conjunction with the learning point above, Children's Social Care should take steps to ensure that all staff are aware of the established points of contact with the Safeguarding Team within the Early Pregnancy Assessment Unit and East Lancashire NHS Trust to ensure effective and appropriate utilisation of these links. Safeguarding information should be shared effectively between health professionals and Children's Social Care especially in cases where there are safeguarding concerns and where the expectant mother has chosen to terminate the pregnancy. Early identification should take place in those cases where it may be necessary to consider the Pan Lancashire Concealed and Denied Pregnancy Guidance and hold early multi-agency discussions as set out in the Guidance.

LP3: Communication between partner agencies should be explicitly clear to reduce any misinterpretation around the confirmation (or not) of termination of pregnancy. Where enquiries are made by safeguarding partners, health colleagues should ensure that the language used is unambiguous and provides definitive information around the termination process.

LP4: Children's Social Care should endeavour to develop and utilise a mechanism by which their case management system can show information regarding a parent's learning disability on the child's digital file. This should enable a new practitioner or worker to have immediate awareness where a parent has a learning disability and to be reminded to view and access supporting information regarding a learning disability which is already stored on the case management system. This will support the early identification of parents with existing and known learning needs and will assist in identifying where additional support may be necessary. Alongside this, practitioners should be reminded to thoroughly review relevant files when cases are allocated to them to ensure that they are they are working with parents in line with their identified learning needs.

LP5: Statutory partners in conjunction with the Children's Safeguarding Assurance Partnership should develop a robust definition to identify which expectant mothers should be treated as 'vulnerable'. This should develop the definition from 'complex social factors' within current guidance to provide greater clarity on wider causes of vulnerability. This will allow women who fall within the developed 'vulnerable' cohort to also be offered enhanced support and care during their pregnancy and any termination they chose to have.

LP6: Information regarding the termination of pregnancies should be conveyed to women's GPs with consent and as part of a patient's health record unless there are expressed reasons for not doing so. In cases where there are safeguarding concerns, termination of pregnancy information should always be provided to the GP in order to inform safeguarding going forward.

LP7: Lancashire Children's Social Care should revisit the Pan Lancashire Concealed and Denied Pregnancy Guidance to reinforce this across teams. Particular attention should be given to convening a multi-agency discussion where concealed pregnancy is suspected and, in such cases, co-ordinating with safeguarding partners in health to offer an ultrasound scan to attempt to confirm pregnancy.

6. Annex A – Panel Membership

The membership of the case review panel was comprised of the following representatives:

Independent Chair	Hazel Gregory
Independent Reviewer	Louise Rae
Business Manager	Children's Safeguarding Assurance Partnership
Panel Member	Lancashire Constabulary
Panel Member	Lancashire Children's Social Care
Panel Member	Virgin Care
Panel Member	Children & Families Wellbeing Service
Panel Member	Lancashire & South Cumbria Foundation Trust (LSCFT)
Panel Member	North West Ambulance Service (NWAS)
Panel Member	Southport & Ormskirk Hospitals NHS Trust
Panel Member	Inspire (CGL)
Panel Member	CAFCASS
Panel Member	East Lancashire Clinical Commissioning Group (CCG) now Integrated Care Board (ICB)
Panel Member	East Lancashire Hospitals NHS Trust (ELHT)