Pregnant women or pregnant people declining antenatal care and/or intending to freebirth

University Hospitals of Leicester NHS
NHS Trust

Trust ref: C27/2025

Contents

1. Introduction and who this guideline applies to 1
Related documents; 2
The Law around Freebirth 2
2. Procedure for Patients Declining Antenatal Care 3
2.1 Notification and Initial Assessment: 3
2.2 Discussion and Provision of Information: 3
2.3 Specialist Support and Referral: 4
2.4 Documentation and Follow-Up: 4
2.5 A Mental Health Capacity Assessment: 5
2.6 Safeguarding: 6
2.7 Multi-Disciplinary Team (MDT) Meeting 7
2.8 The role of the midwife when people are planning freebirth. 8
2.10 Emergency care 11
2.11 Post birth responsibilities: 12
3. Monitoring Compliance 12
Compliance and Review 12
4. Education & Training 12
5. Supporting References 12
6. Key Words 13
Appendix 1: Signs of Safety 14
Appendix 2 MDT Meeting 15

1. Introduction and who this guideline applies to

The University of Leicester Hospitals (UHL) Maternity services recognises the importance of providing comprehensive care to pregnant women and pregnant people while respecting their autonomy and choices. This guideline outlines the protocol for managing cases where people decline antenatal care, to include people who opt for free birthing, ensuring that maternal and fetal wellbeing are safeguarded throughout the process.

What is freebirth?

Across the United Kingdom, there is no specific definition of freebirth, but broadly, the term freebirth is used to describe a pregnant person's decision to give birth (at home or elsewhere) in the absence of and without the assistance of a registered midwife, obstetrician or other registered healthcare professional. Some people may choose the term unassisted childbirth, and the same definition can be applied.
As many freebirth's are never identified to maternity services, the exact numbers occurring each year across United Kingdom is unknown.

It is important to distinguish that there is a distinct difference between freebirth or unassisted childbirth, and those people giving birth at home unintentionally before the arrival of a healthcare professional, known as “Born Before Arrival” (BBA).
All health care professionals should understand that there are many reasons why people choose to freebirth. There is a significant volume of evidence about why people choose to give birth ‘outside the maternity system’ either by choosing a freebirth (without a healthcare professional in attendance), or by choosing to have a homebirth attended by midwives but which is ‘outside of guidance’ (against professional recommendations).

Many people choosing to have an unassisted birth have had previous negative or traumatic personal experience/s, or poor experiences of maternity services. Some people may perceive the risks of attending a hospital to give birth as being greater than giving birth unassisted at home and they may see ‘interference’ in the birth process as a risk/iatrogenic.

Related documents;

- **Booking Bloods and Urine Test UHL Obstetric Guideline**
- **Safeguarding in Maternity UHL Obstetric Guideline**
- **Mental Capacity Act UHL Policy**
- **Consent to Examination or Treatment UHL Policy**
- **Privacy and Dignity UHL Obstetric Guideline**
- **Supporting Birth Outside of Trust Guidance in Low Risk Midwifery Birth Settings UHL Obstetrics Guideline**
- **Concealed or Denied Pregnancy UHL Obstetric Guideline**
- **Domestic Violence Abuse in Maternity UHL Obstetric Guideline**
- **Transfer of Babies to Neonatal Unit from Home or Community Hospital UHL Obstetric and Neonatal Guideline**
- **Parents Declining Transfer of the New-born Infant to Hospital for NEWTT2 Monitoring Standard Operating Procedure**
- **Referral Handover of Care and Transfer UHL Obstetric Guideline**

The Law around Freebirth

Midwives should ensure that people have an understanding of their own rights in relation to childbirth and about the law in relation to unassisted birth and place of birth.

- Freebirth is not illegal; it is completely legal for a person to give birth unattended by a midwife or healthcare professional.
- Pregnant women and pregnant people cannot be compelled to accept care unless they lack the mental capacity with which to make a decision for themselves (Mental Capacity Act, 2005).
- Pregnant women and pregnant people do not face any legal sanction for giving birth without assistance.

- Pregnant women and pregnant people, who have mental capacity, are not obliged to accept or receive any medical or midwifery care or treatment during childbirth. Any care or treatment provided can only be given with a person's consent.
- The maternity service has no right to attend to provide care to a person without their consent.
- The fetus has no legal status until birth.
- According to the Nursing & Midwifery Order (2001) Article 45, it is a criminal offence for anyone other than a midwife or registered doctor to 'attend' a woman during childbirth, except in an emergency.
- Birth partners; including family members and doulas, may be present during childbirth, but must not assume responsibility, assist or assume the role of a midwife or registered medical practitioner or give midwifery or medical care in childbirth.
- It is not appropriate for healthcare professionals to refer a pregnant woman or pregnant person to social services with concerns about the unborn baby, solely on the basis that they have declined medical support, as they are legally entitled to do (Birthrights, 2017). However, if there are safeguarding concerns, the maternity healthcare professional should still follow protocols for referral. This will be pertinent in particular when baby is born.

2. Procedure for Patients Declining Antenatal Care

2.1 Notification and Initial Assessment:

- Upon identification of a pregnant woman or pregnant person declining antenatal care, the community midwife shall inform the Team Lead and Community Matron.

- The community midwife will offer appointments or home visits to discuss the options for care with the pregnant woman or pregnant person.

2.2 Discussion and Provision of Information:

This is a respectful conversation that includes the following discussions;

- The pregnant woman or pregnant person will be provided with a copy of the NICE Antenatal Care guidelines to ensure that they understand the recommendation for antenatal and intrapartum care.

- It is imperative to ensure that a personalised care plan discussion takes place, acknowledging and discussing the pregnant woman or pregnant person's individual risk factors and signposting/referring to health services as required with the pregnant woman or pregnant person's consent.

- Translation services should be offered and utilised to enable thorough discussion. The aim is to provide assurance that there is clear understanding of both;

    - UHL recommendations, services and support is present.
    - UHL staff understand the pregnant woman or pregnant persons preferences and choices.

- Explore and alleviate where possible, the reasons why the pregnant woman or pregnant person has decided to free birth including any poor experience, fear, worries about discrimination or misconception of midwifery led & hospital care.

- This initial conversation will also provide an opportunity to explore whether power and coercive control in their domestic relationship is influencing their decision to free birth, and whether there is evidence of other risk factors, including poor emotional/mental health or drug or alcohol misuse are influencing the avoidance of maternity care.

- Discuss the benefit of scans and blood tests during pregnancy contributing towards the development of a healthy baby.

- If the pregnant woman or pregnant person continues to decline care once they have been informed of the risks, to themselves and their unborn baby and they have capacity, this decision will be respected.

2.3 Specialist Support and Referral:

- The midwife is to liaise with the maternity safeguarding team for advice and supervision on the case, using the Signs of Safety template (Appendix 1). Having explored whether power and coercive control in their domestic relationship is influencing their decision to free birth.
- A Consultant Midwife birth choices review and planning will be offered to the pregnant person.

2.4 Documentation and Follow-Up:

The pregnant woman or pregnant person will be informed that they can seek care at any point should they have concerns about their health or the health and development of their unborn baby or decide to change their mind, and they will be provided with contact details for this purpose. Contact details will include Single Point of Contact number - 0116 2586111 Delivery Suite 0116 2586451, Homebirth team mobile 07717694335 and for birth/post birth the community office on 0116 258 4834 if wishes to engage in care and wants to be seen.

- All interactions and follow-up attempts must be documented in the pregnant person's hand-held and electronic health records.
- If the pregnant woman or pregnant person declines care early in pregnancy, they must be advised that further contacts (Initially a call to ensure wishes to engage and clinic or home visit if agrees?) will be made at 28, 34 and 36

weeks to re-offer care, the relevant community team then document if declined and all documentation to be recorded in the electronic health record.
- The pregnant woman or pregnant person's GP and HV (if known) will be notified, by the community midwife.
- Capacity Assessment and Safeguarding Referral is required.

2.5 A Mental Health Capacity Assessment:

A mental health capacity assessment is a process used by health professionals to determine a person's ability to make informed decisions about their own health care. Simplifying this process involves breaking it down into clear, manageable steps that align with legal and ethical guidelines. Here's how a health professional might approach and complete this assessment:

1. Preparation.

    - Understand the Legal Framework- Mental Capacity Act: making decisions - GOV.UK (www.gov.uk)
    - Ensure that all background information is gathered; Review the person's medical history, current medications, and any previous assessments or diagnoses.

2. Initial Meeting

    - Establish a comfortable environment: Ensure privacy and a calm setting to make the person feel at ease.
    - Build Rapport: Spend a few minutes engaging in casual conversation to establish trust.

3. Assessment Process

    - Clearly explain why the assessment is being conducted and what it involves.
    - Determine if the pregnant woman or pregnant person understands the information relevant to the decision at hand. Ask them to explain it back to you in their own words.
    - Example Questions: "Can you tell me what you understand about your treatment options?"
    - Evaluate Retention: Check if the pregnant woman or pregnant person can retain the information long enough to make a decision.
    - Example Task: After discussing the options, ask them to recall the information after a few minutes.
    - Assess if the pregnant woman or pregnant person can weigh the pros and cons of the options and understand the potential consequences.
    - Example Questions: "What do you think will happen if you choose this treatment?"
    - Ensure the pregnant woman or pregnant person can communicate their decision. This can be through speech, writing, or other means.
    - Example Task: Ask them to clearly state their decision and reasoning.

4. Documentation

   - Document the pregnant woman or pregnant person responses and your observations meticulously.
   - Note any factors that might affect capacity, such as cognitive impairments, mental health conditions, or language barriers.

5. Decision Making

   - Based on the assessment, determine if the pregnant woman or pregnant person has the capacity to make the specific decision.
   - In complex cases, consult with colleagues or specialists such as the perinatal mental health team.

6. Communication of Outcome

   - Explain the outcome of the assessment in an understandable manner.
   - If the pregnant woman or pregnant person lacks capacity, discuss alternative decision-making processes (e.g., involving a legal guardian or using an advance directive).

7. Follow-Up

Schedule follow-up assessments as needed, especially if the pregnant woman or pregnant person condition is likely to change.

Key Points to Remember

- Always approach the assessment with respect for the pregnant woman or pregnant persons dignity and rights.
- Don't make assumptions based on diagnosis alone; each decision requires a specific capacity assessment.
- Provide support to help the pregnant woman or pregnant person understand information and communicate their decision.
- By following these steps, a health professional can conduct a thorough and respectful mental health capacity assessment, ensuring that pregnant woman or pregnant person's rights and well-being are prioritised throughout the process.

2.6 Safeguarding:

Liaison and supervision with the maternity safeguarding team is mandatory and must include maternal and fetal risk factors.

If a pregnant woman or pregnant person wishes to free birth and not receive maternity care from UHL and they have;

- clearly communicated their wishes to health professionals and
- there are no safeguarding concerns identified

no referral to maternity safeguarding is required however, if the pregnant woman or pregnant person has not expressed a wish to freebirth and is not engaging with maternity care, a safeguarding referral needs to be completed.

It is not appropriate for healthcare professionals to make safeguarding/social services referrals with concerns about an unborn baby solely on the basis that the pregnant woman or pregnant person has declined maternity/medical support (which they are legally entitled to do).

Safeguarding referrals should only be made following consideration and discussions with senior midwifery managers, consultant midwife, Community midwifes and the safeguarding team; where there is considered to be a risk of significant harm to the child after it is born.
Following an overview and input by the maternity safeguarding team, a safeguarding referral to social care may be required or kept as information only.

- Staff to consider whether the pregnant person has been coerced into this decision and consider domestic abuse. If a pregnant person discloses domestic abuse a referral must be made to children's social care and UHL maternity safeguarding team.
- Consider any risk to children within the family home, if young children within the home the midwife is to liaise with the allocated health visitor and GP for the family to share patient wishes and to explore safeguarding concerns further

2.7 Multi-Disciplinary Team (MDT) Meeting

Composition:

- An MDT meeting will be scheduled, comprising the Community Matron, Consultant Obstetrician Named Midwife for Safeguarding/Maternity Safeguarding Midwife, Consultant Midwife, GP representative (either safeguarding lead or GP), and a representative from the Integrated Care Board (ICB) Safeguarding team. Meeting template appendix 2.
- Any other relevant agencies involved with the family, such as Drug and Alcohol Services, Health visitor etc. must also be invited for input.
- It is important that prior to the meeting being held that UHL obtain the base folder notes for the pregnant person to ensure that the full medical records of are reviewed, this includes checking all electronic note records within UHL which could detail further information, such as Nervecentre.

Purpose:

The MDT meeting aims to discuss the pregnant person's views while ensuring all risk factors for the pregnant person and unborn child are explored thoroughly. The pregnant person would be informed that the MDT would need to be made aware of their choices to ensure appropriate support is available if required.

- Additional MDT meetings may be required depending on the evolving risks in the pregnancy.

Documentation:

- **Minutes from the MDT meeting will be filed into the maternity records for the person, ensuring visibility for all professionals involved.**

Electronic Notes Alert

- An alert will be placed on the Maternity Electronic Notes System, stating "Declined antenatal care; if contacts maternity services, invite in for full obstetric review."

Risk Assessment and Documentation

- All risk factors, including potential outcomes for the pregnant person and unborn child, will be clearly outlined and documented in the maternity electronic notes system.

2.8 The role of the midwife when people are planning freebirth.

General Principles

- Continuity of midwifery carer, particularly from a named community midwife during the antenatal period should be prioritised. This will enable the person to build a positive relationship, based upon respect and trust with which to support on-going dialogue and engagement with the maternity service.

- Support and advice is most likely to be effective as direct support from a named community midwife who can offer care on a 1:1 basis.

- Large teams of MDT professionals have the potential to feel intimidating, coercive and possibly threatening to some people.

- A flexible approach is required, and appointments may need to be facilitated at the person's home.

- Whilst certain aspects of a recommended package of care (for example, scans or screening tests) may have been declined, other aspects of care, discussion and advice may be accepted and/or welcomed by the person.

- As with all people, an individualised and personalised approach is needed.

When a person indicates to their midwife that they plan to give birth without assistance, the maternity service should reach out to the person to support an on-

going supportive and respectful dialogue and should include arranging for the named community midwife to spend time talking with the person (and their partner, if appropriate) to understand more fully their concerns and reasons for their decisions.

During the conversation/s;

1. the person should be given time to share what is important to them in relation to their physical and psychological safety.

2. the midwife should sensitively explore why the person wants to have an unassisted birth. Ask what plan for their birth would feel safe and acceptable to them, and consider options of how to provide an individualised plan of care.

3. the midwife should sensitively explain the evidence about any particular individualised risk factors for the pregnant person and their baby around their intended birth plan.

4. the midwife should identify any misconceptions or misunderstanding about current practice or service provision in the area and provide them with accurate information.

5. an opportunity should be sought to have a one-to-one conversation with the pregnant person about their wishes and plans, without the presence of their partner or other family members. Consideration should be given to the possibility of coercion or pressure being placed on the pregnant person to have an unassisted birth.

6. Reassure the pregnant person that they will continue to be offered and fully supported to have antenatal and postnatal care (if they wish for this), even if they have decided to have an unassisted birth.

Following discussions, give the pregnant person time to reflect upon their decision and whether they continue to wish to proceed with planning an unassisted birth, and explore their individual needs around any further information or support that they would like from the maternity service.

1. Advise the pregnant person how to notify and register their baby's birth if they have an unassisted birth.

2. Community midwife to advise if the pregnant person has an unassisted birth, they must first 'notify' the birth of their baby to a relevant public body within 36 hours. This is a legal requirement. The legal duty to notify is set out in **the National Health Service Act 2006 Section 269 (4)-(6)**

3. The named community midwife is encouraged to gain support, advice and reassurance from: their line manager, Consultant midwife, perinatal mental health team (where appropriate), safeguarding team (where appropriate), neonatal and obstetric colleagues.

4. Senior midwifery managers/consultant midwife should be informed of all people who intend to freebirth.

5. All discussions should be documented fully in the person's notes and an Individualised Birth Plan should also be completed and shared onto the electronic health records to reflect the discussions that have taken place.

General Guidance:

If there is any uncertainty or hesitation regarding a plan, healthcare professionals should prioritise people's safety and well-being. It is always safer to seek clarification and escalate concerns rather than agree to a plan that doesn't feel right.

Discuss Risks highlighting that a delay in seeking Midwife or Medical attention may result in morbidity or mortality for mother and baby, potential complications include, the list is not exhaustive:

Risks	Discussed	Risks	Discussed
Haemorrhage • During- intra • After- post Infection Retained Placenta Perineal trauma Uterine Rupture / Inverted uterus Delay in resuscitation Maternal collapse- hysterectomy /death Maternal morbidity Maternal mortality Management of 3rd stage		Presentation • Breech • Transverse • Occipito posterior Fetal distress leading to avoidable intrapartum Stillbirth Prolonged labour Uterine rupture Delay in delivery /resuscitation - • Shoulder Dystocia – Brachial Plexus injury • Cerebral Palsy • Neonatal Death Failure to initiate feeding- hypoglycaemia/ hypernatraemia, dehydration = possible neurological damage Jaundice- kernicterus	
Document information giving as appropriate:			
		Post birth advice, to be given when appropriate	

		• Disposal of placenta. • Infant feeding • Postnatal service • Registering birth	

Name of Midwife……Signature……..Date……

Important note: all advice and guidance must be clearly and fully documented onto Electronic health records.

2.9 Intrapartum discussion

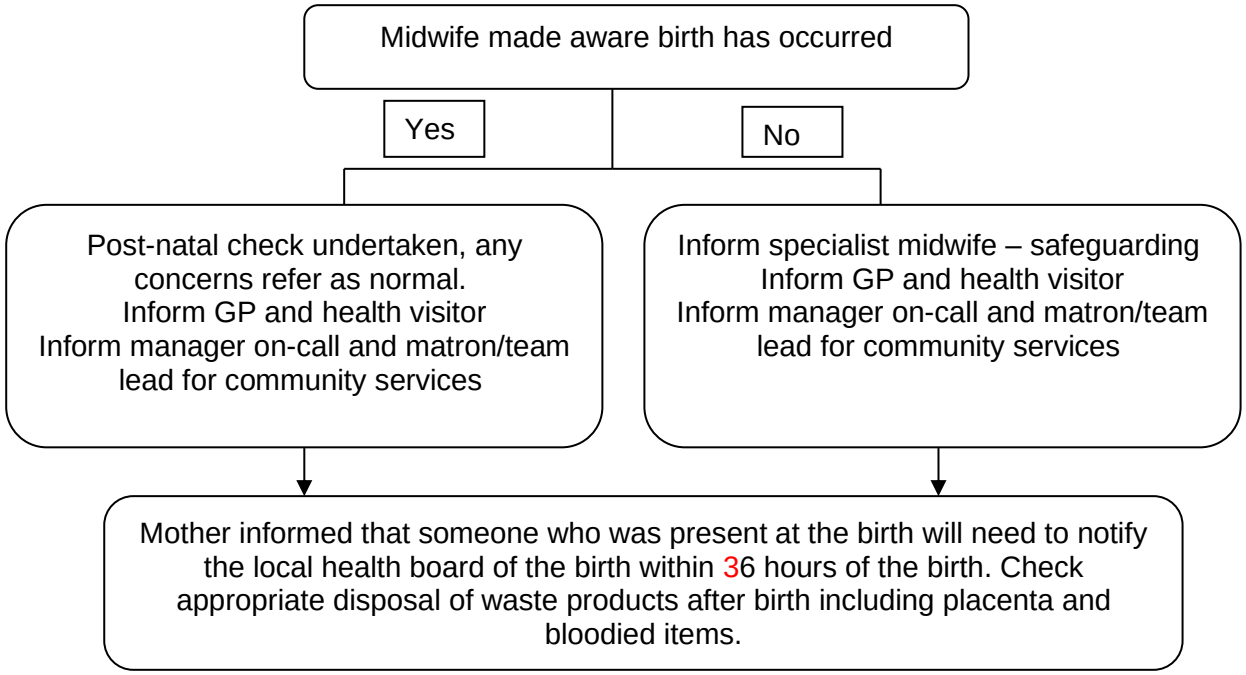
- If a midwife is called and then care is declined and the midwife is asked to leave – an intrapartum discussion is usually undertaken by clinical midwife called. This is a challenging discussion as the birthing person is likely to be distressed.
- If a midwife is called and the birth has not occurred, any benefits, risks or concerns should be discussed with the birthing person and documented. (NMC 2018).
- Should the midwife have any concerns in relation to the mothers physical or psychological wellbeing, mental capacity or safety they should refer to the appropriate professional – GP, consultant obstetrician, mental health services, and independent advocate.
- Always inform the manager on call and a clinical supervisor for midwives (where possible) (NMC 2018).

2.10 Emergency care

If the pregnant person is birthing and calls an ambulance, the ambulance service will recommend conveyance to hospital for ongoing care. If the pregnant person declines this, the ambulance service will require a midwife to attend the address to take over clinical responsibility. The pregnant person should be informed of this at the time of discussing the risks of free birthing.

Emergency care; the Homebirth Team could be contacted but may not be available to attend. It would need to be highlighted that the pregnant person had chosen to free birth but now required care and refuses transfer. It would need to be reviewed and discussed with HBT and delivery suite depending on situation at the time.

2.11 Post birth responsibilities:



3. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Audit	Audit maternity patient's who have declined antenatal care and/or intend to free birth.	Community Matron	Annually	

Compliance and Review
Compliance with this SOP is mandatory for all staff involved in maternity care.
Regular reviews of this SOP will be conducted to ensure alignment with best practices and NMC Guidance
This SOP serves as a comprehensive guide for managing cases of patients declining antenatal care and opting for free birthing, ensuring that maternal and fetal wellbeing are prioritised while respecting patient autonomy and choices.

4. Education & Training

None

5. Supporting References

1. Mental Capacity Act 2005. https://www.legislation.gov.uk/ukpga/2005/9/contents

2. Nursing & Midwifery Order (2001) Article 45
https://www.legislation.gov.uk/uksi/2002/253/article/45
3. Birthrights, 2017 Impact report 2017/18. Protecting human rights in childbirth.
https://birthrights.org.uk/wp-content/uploads/2019/05/Impact-report_A4_RGB_spreads.pdf
4. Mental Capacity Act: making decisions – September 2014 (updated June 2023)
https://www.gov.uk/government/collections/mental-capacity-act-making-decisions
5. **The National Health Service Act 2006 Section 269 4-6**
https://www.legislation.gov.uk/ukpga/2006/41/contents
6. NMC 2018: The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates.
https://www.nmc.org.uk/standards/code/

6. Key Words

Freebirth, `Born Before Arrival` (BBA), Safeguarding

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Lynn Cunningham - Matron			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
April 2025	**1**		**New document**

Appendix 1: Signs of Safety

What are we worried about?	What's Working Well?	What needs to happen?
On a scale of 0-10 where ten means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children that they cannot live at home, where do we rate the situation? Locate different peoples judgements on the two-way arrow **0**  **10**		

Appendix 2 MDT Meeting

MDT Meeting for Decline of Antenatal Care and/or Intension to Freebirth

Patient Name:	**Date of Birth:**
Hospital Number:	**EDD:**
Date and time of MDT	**Allocated Midwife:**

Professionals involved

Professional Name	Job Role	Invited	Attended	Contact details

Summary

Name (print):

Signature: **Date**

Known Risk Factors

Plan

Date of follow up MDT if required-