

Protecting all vulnerable babies better

National review into the broader issues raised by the death of baby Victoria Marten

This short briefing note aims to summarise the key learning points from the independent Child Safeguarding Practice Review Panel's national review into the death of Baby Victoria Marten. It outlines forward-looking, preventative and practical recommendations to strengthen safeguarding for all vulnerable unborn babies and infants under 1. Its findings explore working with parents who do not engage with services, domestic abuse, concealed pregnancies, managing child protection risks associated with serious offenders and families who move frequently.

It sets out eight national recommendations for improving protections for unborn babies and infants under 1 alongside 11 specific recommendations for safeguarding partners and one for Inspectorates. Read the full report here:

<https://www.gov.uk/government/publications/protecting-all-vulnerable-babies-better>

About the national review

Baby Victoria was born in December 2022 and died in early 2023. In 2025 both of baby Victoria's parents were convicted of gross negligence manslaughter, child cruelty, perverting the course of justice, and concealing the birth of a child.

The review followed a four-phase structure – evidence gathering, thematic analysis, development of findings and formulation of recommendations. It included 43 interviews with around 53 professionals from various agencies, three practitioner workshops and analysis of 41 local reviews to identify systemic challenges.

What can we learn about the safeguarding system from what happened to Baby Victoria?

There must be greater support for parents who have had children removed

- Prior to Baby Victoria's birth, the family history demonstrated a sustained and serious pattern of concealed pregnancy, avoidance of services, child protection investigation and subsequent child removal and a broader context of domestic abuse, serious offending and frequent moves between different areas. Our evidence from a number of safeguarding reviews shows that when parents do not engage, agencies must focus harder on understanding why — this may reflect grief, trauma and mistrust, particularly in the context of previous child removals.
- Practitioners need to work skilfully and persistently, potentially over an extended period of time, to build effective relationships with parents who may be evading services or struggling. This includes trying to address the underlying issues that led to previous child removals.

- Practitioners across all relevant agencies also need to work together to triangulate what information is known about a family and to understand the full extent of their needs. This focused effort will help inform the content of a parent support offer that is more likely to work and enhance understanding of any wider safeguarding risks – including planning for future pregnancies.

Concealment of pregnancy/birth occurs for many reasons but can be a response to trauma and grief

- It is a woman's right not to disclose her pregnancy, which can limit the ability of safeguarding practitioners who are concerned about an unborn baby to intervene.
- While we want government to review and update national safeguarding guidance to include a much greater focus on the protection of unborn babies, practitioners need to view concealment as a safeguarding concern and consider contextual information, particularly where previous removals have been made.
- Practitioners need to work with women and parents throughout the entirety of pregnancy, not just in the final weeks before birth. Building a relationship early is essential to understanding risk, supporting engagement and promoting the safety of the unborn baby, especially where there is a history of repeated child removal or trauma.

There needs to be a stronger relationship between children's social care and offender management agencies

- Serious offenders who are parents or carers can pose complex risks to children and the review found that children's social care and offender management agencies often work in isolation, leading to critical information regarding the vulnerability of parents and/or children not being fully understood.
- Practitioners should actively seek collaboration and engage with offender management agencies at both an operational and a strategic level to ensure that children's safeguarding is not compromised. When serious offenders do not engage with practitioners, it significantly limits the ability to assess and manage risk. Practitioners should treat non-engagement as a risk factor in itself and seek wider inter-agency support to understand and respond to this behaviour.

Families who move frequently can signal risk

- Repeated relocations, especially during pregnancy or while subject to child protection processes may indicate attempts to evade agency oversight. Moves should be treated as a potential safeguarding concern, not just a logistical change.
- Where families have a history of moving and safeguarding concerns exist, agencies should proactively plan for future moves - including having up-to-date chronologies, assessment summaries and agreed contingency plans in readiness for the next move.
- Agencies should maintain concise, high-quality summaries of work undertaken and risks identified, and include any nuances of professional judgement that need to be shared and understood. These should be readily available in the event of a move, to ensure continuity and safety.

Questions that you might want to reflect upon as a professional:

We have set out below some questions that you might want to reflect upon as a professional, either individually, as part of supervision, or as a group.

Learning from the review

1. What are the key lessons in this national review for your organisation and your practice, including working with other agencies (including with offender management services, police, other local authorities)?
2. Looking at the learning from this national review, do you have any reflections on whether you and your colleagues could have acted differently when responding to instances of non-engagement, families who move or concealed pregnancies?
3. Looking at the key recommendations in the review for safeguarding partnerships, what are the immediate steps you and colleagues can practically put in place with respect to the protection of vulnerable unborn and newborn babies?

Working with parents

4. How does your practice need to change so that the needs, concerns and previous experiences of families who move frequently or do not engage are better addressed?
5. How can your practice develop in order to implement more effective multi-agency parental support planning after the removal of a child?
6. How well is mental health understood and addressed when dealing with concealed pregnancies or births?

The recommendations for Safeguarding Partnerships are:

Multi-agency protocols

Safeguarding partners should have a multi-agency pre-birth protocol for unborn babies that includes concealed pregnancy, with a focus on vulnerable babies, when there are child protection risks.

Pre-birth protocols

Safeguarding partners should review the quality, robustness and consistent implementation of pre-birth protocols to ensure practice and delivery is in line with best practice guidelines.

'Think Family' approach

Safeguarding partners should ensure that a 'Think Family' approach is taken when identifying multi-agency pathways of support for parents whose children have been removed into care. This should include:

- a. working with all relevant adult services to develop, implement and resource parental engagement strategies and parent support plans that address all known vulnerabilities
- b. convening local stakeholders to audit and review existing services in the context of supporting parents whose children have been removed into care, identifying gaps and assessing whether current services can be adapted or if additional provision is required (this should encompass a broad range of relevant services, including domestic abuse, mental health, housing and substance misuse services)

Multi-agency reflection and joint approaches

Safeguarding partners should ensure that it is standard practice in local areas to facilitate multi-agency reflection to enable practitioners from all agencies routinely to reflect on and collectively consider approaches to their work with complex families. This should include families who do not engage when there are child safeguarding concerns.

Accessibility of services for families

Safeguarding partners should assure themselves, including through regular audit and data collection, that services are universally accessible to families who may find it difficult to engage and access support. This should include a consideration of all aspects of their identity, including their ethnic and cultural backgrounds, and their wider circumstances.

Trauma skills and understanding

Safeguarding partners should ensure that practitioners across all agencies, from universal to specialist services, have a shared understanding of trauma and the skills, knowledge and understanding to support families to engage with services. Safeguarding partners should refer to the working definition of trauma-informed practice in their consideration of defining and responding to trauma. This means anticipating risk for unborn infants, sustaining post-removal support for parents beyond statutory timescales, and embedding multi-agency collaboration at every level.

Involvement of criminal justice services

Safeguarding partners should assure themselves there is appropriate input and involvement from criminal justice services in the development and implementation of local multi-agency child protection teams.

Cooperation and oversight of sex offenders

Safeguarding partners should review their local MAPPA and MARAC arrangements to ensure oversight of all risks in relation to offenders and safeguarding of children; noting that, while MAPPA is led by police, probation and prison services, other agencies such as children's social care, housing, education and health have a duty to co-operate. The findings of this national review should be shared with the local MAPPA and MARAC boards as part of this local review.

Impact of domestic abuse on babies and children

Safeguarding partners should assure themselves that every frontline practitioner understands the impact of domestic abuse on babies and children, knows how to

recognise coercive control, has knowledge of local support systems and how to make MARAC referrals.

Missing vulnerable women and unborn babies

Safeguarding partners should ensure that where practitioners are concerned for the welfare of a missing vulnerable woman and her unborn baby, CP-IS is updated by children's social care if there is a child protection plan in place. The [NHS Safeguarding Missing Person Protocol](#) should be followed by health providers.

Having key information ready to share

In the context of families who move frequently, safeguarding partners should ensure that the case summary, risk assessment and intervention approach planned for families is completed by all agencies with input from relevant services including education, early years and universal services where appropriate. This should be consistently updated and be ready to share as information requests from other areas are received in line with the timescales set out in Working Together to Safeguard Children.

How can we improve nationally?

The Panel is calling for government to make several additions to the next version of Working Together to Safeguard Children, improve guidance for multi-agency collaboration and further strengthen registration requirements for sex offenders.

The next version of Working Together to Safeguard Children should:

- include a new section on safeguarding and child protection for babies that includes content on vulnerable babies, concealed pregnancy and pre-birth planning for unborn babies when there are child protection risks.
- make clear that safeguarding partners need to work with all relevant adult services to develop, implement and resource effective parental engagement strategies.
- include a definition of trauma on which safeguarding partners, agencies and organisations can base their approaches to trauma-informed practice, with reference to the working definition of trauma-informed practice.
- reflect the HMPPS Child Safeguarding Policy Framework, which requires all Heads of Probation Delivery Units to attend local safeguarding partnership meetings where required.
- reflect MAPPA statutory guidance which states that, one or more people who can reflect the range of social services responsibilities, including children and vulnerable adults should be members of MAPPA Strategic Management Boards.
- make clear that where a child in need or a child with a child protection plan moves between local authority areas, there are robust, formal processes in place to transfer information.
- set out the necessary principles for local areas to follow in situations where there is a lack of clarity about which local authority should be responsible for a child.

Recommendation 4: MAPPA guidance

HMPPS should update the MAPPA guidance to clarify the relationship between MAPPA agencies and multi-agency safeguarding arrangements and highlight child safeguarding in the thresholding document.

Recommendation 5: Registered sex offenders

Government should strengthen the registration requirements for registered sex offenders in the Sexual Offences Act 2003 to include a requirement to inform the police of the name of new partners and to notify the police within a specified period of time if they or their partner is due to give birth.