

Introduction

The national review titled “Protecting all Vulnerable Babies Better” was prompted by the tragic death of baby Victoria Marten in early 2023. While the circumstances of her short life were unique, the professional challenges encountered in the years, months and weeks leading up to her birth are not.

Strengthening safeguarding for unborn and highly vulnerable infants requires proactive, trauma informed, and coordinated multi agency practice, with a strong focus on anticipating risk and maintaining professional curiosity.

The key findings and learning are noted below for everyone with a role in children’s safeguarding and child protection, and for people working with complex adults to consider and act upon.

Non Engagement

Across multiple pregnancies and local authorities, the parents persistently avoided assessment, withheld critical information, and disengaged entirely from services. Practitioners must not view non engagement as refusal alone, reviews show it often reflects trauma, mistrust, grief, or previous child removals.

Non engagement should trigger heightened professional curiosity, risk escalation, and coordinated multi agency planning, not reduced contact or case closure.

Concealed Pregnancy

The review of Victoria found the pregnancy was intentionally concealed, removing all opportunities for pre birth assessment, planning, or protective action. Concealment may emerge late in pregnancy, during labour, or after birth. Practitioners must ensure concealed pregnancy is treated as a significant safeguarding indicator, with clear pathways for verification, escalation, rapid assessment, and information sharing, especially when there is a pattern of recurrent pregnancies and previous removals.

Domestic Abuse & Offending

The family history involved significant domestic abuse and a background of serious criminal offending, creating complex risk dynamics. The national review stresses the importance of close coordination between adult and children’s services, including offender management, probation, and domestic abuse pathways. Risk remains present even when parents refuse to engage. Practitioners must consider coercive control, hidden risk factors, and the cumulative impact of trauma when forming assessments.

Cross-Border Risk

Frequent, often deliberate movement across local authority are a key risk factor, often signalling attempts to evade oversight or reflecting trauma driven “flight” and prevent professionals from maintaining oversight. This highlights the need for robust transfer processes, monitoring systems, and immediate information exchange when families relocate. Agencies should avoid delays in establishing responsibility and ensure continuity of safeguarding planning, regardless of geography.

Professional Curiosity

Effective safeguarding requires agencies to move beyond information sharing and engage in shared analysis, reflective discussion, and joint problem solving, especially when direct access to the family is limited. Practitioners must maintain professional curiosity, challenge assumptions, and escalate concerns collaboratively when warning signs accumulate. Multi agency reflection becomes essential when risk is escalating but invisible, as in cases of concealment, non engagement, or mobility.

BSCP Training and Guidance

The partnership delivers a range of training courses focused on engaging families and domestic abuse, which can be accessed via POD.

National guidance can be accessed here:

- [Working Together Safeguarding 2026](#)
- Office for Health Improvement and Disparities, 'Working definition of trauma informed practice', (2022), available at: [Working definition of trauma-informed practice - GOV.UK](#)

Recommendations and Reflections:

As a safeguarding partnership, we ask that you consider and reflect on the following within your organisation:

1. How well does your service explore the reasons behind parental non engagement or missed appointments, rather than defaulting to assumptions of resistance or non compliance? Do practitioners reflect on their own barriers to engagement?
2. Within your organisation how do you reinforce professional curiosity, respectful challenge and persistence when engagement is difficult?
3. How effective does your organisation support early identification of risk to unborn babies particularly where pregnancies are concealed or disclosed late?
4. How well is your service aware of our local offer of services for parents who may be vulnerable during pregnancy?
5. How well does your organisation equip practitioners with the confidence, guidance and supervision needed to work with families where serious offenders are involved?
6. How does your organisation respond when victims of domestic abuse do not engage, ensuring this is interpreted as potential increased risk rather than lack of consent or reduced concern?
7. How effectively do we recognise and respond to coercive control, particularly where abuse is not visible or disclosures are limited?
8. How robust are your local protocols and cross border arrangements in preventing safeguarding drift when families move?

Full Report

You can access the full National Review here: [Protecting all vulnerable babies better National review into the broader safeguarding issues raised by the death of baby Victoria Marten](#)