THE CHILD
**SAFEGUARDING**
PRACTICE REVIEW PANEL

# Protecting all vulnerable babies better

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

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# Foreword

This national review is rooted in the tragic circumstances of baby Victoria's short life and untimely death, but its purpose is forward-looking, preventative and practical: it aims to strengthen safeguarding for all vulnerable unborn infants and babies. It is hard to imagine anyone more vulnerable than an unborn infant or a tiny baby, but 1,430 unborn infants were subject to child protection plans (CPPs) on 31 March 2025 and 3,930 children aged under one were subject to CPPs on the same date.[1] These infants are tremendously vulnerable, but they are not rare. There are thousands of them.

The review makes clear that Victoria's four older siblings were well protected by services and that professionals across agencies acted with skill and dedication to keep them safe. At the same time, the review does not shy away from the fact that Victoria's birth was the last within her family of a rapid series of pregnancies, births and removals into care that by the time she was conceived had become a repeating pattern with devastating consequences.

The broader themes we explore in this review are present in many of the rapid reviews and Local Child Safeguarding Practice Reviews received by the Child Safeguarding Practice Review Panel every year. We know that in every safeguarding partnership across England, leaders and practitioners are grappling with the significant challenges presented by families who do not engage with statutory services or who conceal their pregnancies, who are struggling with domestic abuse, who include serious offenders or who move areas and become difficult to trace. These broader issues can all impact enormously on the protection of children, and they were all present in Victoria's family circumstances and in many of the other reviews considered by the Panel over the years. These complex themes all require considered responses and effective service provision.

However, the review also highlights a critical lesson: keeping children safe by removing them with just cause from their parents only serves to protect those children. It does not address the root of the problem, and it does not prevent the same set of circumstances from happening again. Indeed, it may increase the risk of harm for the next child, not yet born, not yet even conceived. This review encourages all of us to imagine the trauma and grief of having multiple children removed one after another and to think much harder about what parents in that unenviable situation need in terms of ready access to effective support.

1 Department for Education, 'A5 National time series of child protection plans by initial category of abuse by sex, age and ethnicity', (2025), available at: https://explore-education-statistics.service.gov.uk/data-tables/permalink/226d7972-f674-439a-4a32-08de398c3998

It is evident of course that only a very tiny number of parents who come to the attention of agencies will commit anything like the awful criminal offences that led to Victoria's death. But many more of that same group of parents will have experienced considerable trauma in their lives and will be grappling desperately with the continuing impacts of that trauma. Trauma that is inevitably made even worse if their children are subsequently removed from them – however right that decision to remove may be. Trauma that can often only be made bearable by bringing another baby into the world. We must understand and engage better with these realities of human experience, choices, reactions and suffering if we are to stop these cycles of risk and harm from repeating themselves in the future and change lives for the better.

This is undoubtedly hard to hear and harder still to action. The implication is that we must keep a focus on the parents in these situations, however hard to understand they may be, as well as the vulnerable baby or the unborn infant. It means persisting in trying to engage with parents who may not want to be engaged with at all and who may be doing everything they can not to engage with practitioners. It means being relentless in our efforts to build trust where no trust exists and in working out what might help to make a difference. But this must be done if destructive cycles of harm are to be interrupted. This is not a challenge for children's social care alone. It demands a whole-system response: adult services, police, probation, GPs, midwives, health visitors and all safeguarding partners acting together with clarity and purpose.

This review calls for an important shift in practice. We want the whole multi-agency system to combine its collective knowledge and experience to get underneath the causes of parental non-engagement and move further toward proactive, relational and trauma-informed practice. Our recommendations are intended to help the system to do this, and safeguarding partners should reflect on the recent children's social care reforms, including the Families First Partnership Programme, and anticipate the opportunities presented by the Children's Wellbeing and Schools Bill when addressing this in their local areas. These developments offer a framework for embedding multi-agency child protection teams and a preventative 'Think Family' approach across the whole children's safeguarding system.

The social and economic benefits are clear too. We know from the independent review of children's social care that, in 2021, the provision of public services for every child who entered care were valued at £70,900 per year, compared to £26,900 for children who need a social worker.[2] Intervening in family life is expensive for the public purse, and repeatedly intervening in family life is very expensive indeed. There must be an economic case for investing in proactive engagement strategies and service provision that disrupts cycles of harm.

The implications of this review extend far beyond local practice. We look forward to a response to our national recommendations from government within six months of publication of this report. They must also inform the future remit of the proposed Child Protection Authority, ensuring that national oversight drives consistency, anticipates risk and promotes integrated responses to complex harm.

Victoria's tragic story is a stark reminder of what is at stake. Protecting vulnerable babies better requires us to act collectively, think systemically and hold in mind not only the child before us but the child who may come next. And it requires us to see effective engagement with a vulnerable child's parents as a necessity, not an option.

That is the challenge, and the responsibility, this review sets before us.

**Sir David Holmes CBE**
Chair, Child Safeguarding Practice Review Panel

2 Department for Education, 'Independent review of children's social care: final report', (2022), available at: www.gov.uk/government/publications/independent-review-of-childrens-social-care-final-report

# Executive summary

This national review 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. These challenges, persistent parental non-engagement, concealed pregnancy, frequent moves and complex risks such as domestic abuse and serious offending, are reflected in rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) received by the Panel from local safeguarding partners every year.

The purpose of this review is not to revisit criminal proceedings but to identify systemic learning that can strengthen safeguarding practice for all vulnerable babies. Victoria's parents were wholly responsible for her death, but Victoria's story cannot be understood without recognising the history of her siblings and without considering the cumulative impact of trauma and repeat child removals on her parents. Safeguarding unborn and highly vulnerable babies requires a proactive, relational and trauma-informed multi-agency system that anticipates risk and prepares for future pregnancies.

The key findings and recommendations from the national review are provided below for everyone with a role in children's safeguarding and child protection, and for people working with complex adults, to consider and act on.

## Key findings

Through primary fieldwork with practitioners, consultation with national and representative agencies and organisations, analysis of child safeguarding reviews and wider evidence and research, the review explores working with parents who are not engaging with safeguarding agencies, concealed pregnancy, managing the child protection risks associated with serious offenders, domestic abuse, and families who move frequently.

Key learning for practitioners from each chapter is highlighted below.

# Engaging parents

Safeguarding children becomes particularly challenging when parents are unable or unwilling to engage with statutory agencies. Persistent non-engagement limits practitioners' ability to understand family dynamics, assess risks and build the relationships necessary to protect children, including those who are unborn. Without meaningful engagement, professionals cannot identify or address the support needs of key adults in the child's life, which is essential for ensuring safety and wellbeing. Parents may avoid engagement for various reasons, such as their personal histories involving trauma, domestic abuse, substance use or mental ill health, previous negative experiences with safeguarding agencies, or unmet service needs. A relational, trauma-informed, system-wide approach is therefore crucial, enabling practitioners in all relevant services to build trust while recognising that trauma can affect parenting capacity, but this does not remove a parent's responsibility to keep their children safe.

Improving engagement requires a holistic, whole-family approach that integrates children's services, adult services, criminal justice and health services to address issues like poor mental health, domestic abuse, substance use and insecure housing. Multi-agency collaboration is vital for shared reflection and systemic thinking to manage risk and avoid reactive interventions. Trusted professionals such as GPs, midwives and health visitors can play a key role in identifying risk and encouraging engagement. Long-term preventative work should align with recent children's social care reforms, including the Families First Partnership Programme, which aims to embed a 'whole family' approach throughout the system. This co-ordinated effort ensures that safeguarding is proactive, comprehensive and responsive to the complex needs of families.

## Key learning for practitioners: engaging parents

**Non-engagement needs to be actively understood and addressed.** Practitioners should consider whether avoidant behaviour may be rooted in trauma, rather than assuming it reflects deliberate resistance. This understanding is essential to safeguarding both current and future children.

**Trauma does not remove parental responsibility.** While trauma may affect a parent's capacity to engage, it does not negate their moral and legal duty to act in their child's best interests. This principle should remain central to safeguarding practice.

**Practice should be trauma-literate and intersectional.** Professionals need to recognise how trauma, discrimination and systemic bias may shape parental behaviour. Responses should be adapted to help parents feel safe enough to engage, while maintaining a clear focus on the child's welfare.

**Multi-agency reflection is essential.** When parents do not engage, agencies should create structured opportunities for joint reflection and shared problem-solving. Strong information sharing is not enough: there also needs to be a shared discussion space for analysis and co-ordinated action.

**Support needs to extend beyond proceedings.** Parents who have experienced trauma may require long-term, relationship-based support that continues beyond the conclusion of care proceedings. This is vital to reduce the risk of future harm and to support potential future parenting.

**Support needs to be personalised.** It may take parents years to be ready for therapeutic interventions, and support to address other presenting issues may be the more pressing priority. A spectrum of co-ordinated support should be available. It can be bespoke to what parents need and can cope with at different points in time in their individual journeys to achieve lasting change.

**Systemic responsibility matters.** Engagement should not rest solely with parents. Safeguarding services should be designed to build trust, anticipate resistance and offer practical, co-ordinated help that meets parents' needs.

**Specialist support needs to be distinct from statutory safeguarding roles.** Parents who have experienced trauma may struggle to engage with professionals they associate with past harm, particularly those involved in child removal. Safeguarding systems should offer access to separate, specialist support that enables parents to process their experiences and build trust without conflating therapeutic engagement with statutory authority.

# Protecting babies and unborn infants

The concealment of a pregnancy can be a response to trauma, fear of further child removal, domestic abuse or exploitation, and can be linked to unresolved grief and mistrust of services. There is a tension between balancing a woman's right to bodily autonomy and privacy with the duty to protect unborn infants from harm. While local safeguarding partners and NHS Trusts have developed guidance for pre-birth assessment, there is no national statutory framework, creating inconsistencies in practice. Gaps in systemic practical and therapeutic support and inconsistent post-removal support can exacerbate vulnerability, leading to disengagement and potential concealment of pregnancy.

The learning from this review identifies the need for a trauma-informed, preventative approach that prioritises early, relational work with parents, especially those with histories of child removal. Multi-agency post-removal parent support plans should address emotional and practical needs, anticipate future pregnancies and ensure continuity of support beyond care proceedings. Integrating adult services such as mental health, housing and substance misuse support is essential to break destructive cycles of harm. National guidance and equitable access to support services are critical to improving outcomes for both parents and children. Safeguarding practice must shift from reactive interventions to proactive strategies that build trust, address grief caused by child loss and prevent tragic outcomes for vulnerable families wherever possible.

## Key learning for practitioners: protecting babies and unborn infants

**Concealed pregnancy may be identified late in pregnancy, during labour or following delivery.** It is important for agencies to understand the background of the mother in order to support her needs.

**There is no legal duty to disclose pregnancy.** Women do not have to seek or accept any midwifery or medical care during their pregnancy or childbirth. Unassisted birth is a matter of choice and not in itself a reason for raising safeguarding concerns with other agencies. This can limit the ability of safeguarding professionals who are concerned about an unborn infant to intervene, unless a pregnancy is disclosed or detected.

**Assessment of risk.** Where practitioners or agencies are concerned that the unborn infant may be at risk of significant harm, a referral is made to children's social care, which will decide whether further assessment is required to identify risk, offer support or develop a safety plan.

**Concealment occurs for many reasons and may be a trauma response, rather than avoidance.** Concealed pregnancies can be a deliberate attempt by parents to avoid further loss after previous children have been removed. This behaviour may reflect deep trauma, grief and mistrust of services.

**Concealment is a significant safeguarding indicator.** Practitioners need to view concealment as a serious safeguarding concern, and consider contextual information, particularly where previous removals have been made.

**Safeguarding unborn infants requires proactive, relational work.** 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 infant, especially where there is a history of repeated child removal or trauma.

**Support should continue beyond the end of care proceedings.** The end of care proceedings should not mark the end of professional involvement. To prevent recurring cycles of harm, parents need long-term, trauma-informed support to process loss and reduce the risk of future concealment or harm. This support should also address wider emotional and practical needs, including mental health, substance misuse, housing and experiences of domestic abuse.

**Multi-agency planning needs to consider and respond to parental needs.** Formal parent support plans should be developed alongside child protection plans. These should address grief, trauma and practical needs, for example assistance with housing or addressing substance misuse. Agencies with specialist expertise, including adult mental health and loss, should be involved.

**Specialist services are not consistently available.** Access to post-removal therapeutic services is patchy across England. Where available, services with a strong evidence base, such as Pause or FDAC, demonstrate improved outcomes in breaking cycles of repeat removals for parents. These services often work in partnership with adult services, which is essential to addressing the full spectrum of parental needs and reducing future risk. Safeguarding partners could consider the breadth of adult and children's statutory and voluntary services currently available and consider how these can be set out and utilised effectively within a coherent parent support framework.

**Systemic gaps can escalate risk.** When post-removal support is unavailable to parents, their needs may go unmet or be overlooked. This can lead to escalating mistrust, disengagement, and ultimately, tragic outcomes.

# Managing the child protection risks associated with serious offenders

Serious offenders who are also parents can fall between the gaps of the criminal justice and child protection systems. When offender management services do not fully consider parenting responsibilities or the risks that offenders pose to children, safeguarding assessment and intervention can be delayed or ineffective. To address this, multi-agency public protection arrangements (MAPPA) should embed child protection and safeguarding as a core priority, including at Level 1, and ensure that complexity or non-engagement triggers multi-agency oversight and reflective practice. Practitioners working in statutory safeguarding agencies require access to specialist offender-management knowledge, clear guidance and strong multi-agency networks to manage risk effectively and help protect children from harm.

Practitioners must also consider factors such as an offender's experience of custody, engagement with rehabilitation, mental health and substance use, and the impact of racism and discrimination. Extended incarceration, particularly from a young age, is associated with trauma, and it can influence how offenders interact with authority and seek support, shaping parenting and co-operation with practitioners long after release. The current system is heavily assessment-driven yet limited by capacity. Offenders who do not engage can be excluded from support which could, in turn, increase risk in families.

## Key learning for practitioners: serious offenders

**Child protection and offender management should be integrated.** Serious offenders who are parents or carers pose complex risks to children. These risks are often not fully understood and can be underestimated when child protection and offender management systems operate separately. 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.

**MAPPA Level 1 management has limitations.** The most serious offenders are supervised at Level 2 or 3, but the majority of those assessed as serious offenders are supervised at Level 1. Management at Level 1 includes multi-agency support, and there is still a legal duty to share information, to work together and to assess risk. In complex cases, where there is concern about gaps in an offender's risk-management plan that impact on child safeguarding, MAPPA Level 2 meetings can bring in additional, formal multi-agency oversight. This can be helpful even where children's services are already involved.

Under the Sexual Offences Act 2003, RSOs must notify police of travel, changes of address and if they are residing in households with children.[3] Practitioners talking to each other, including in their meetings under MAPPA Level 1 or through other safeguarding arrangements, can help build a picture of potential safeguarding risk.

**Non-engagement signals risk.** 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.

**Understanding the impact of incarceration.** Long custodial sentences, especially those served in adult prisons during adolescence, can affect an individual's ability to engage with practitioners. Practitioners should consider the psychological and relational impact of incarceration when assessing parenting capacity and risk.

**Specialist expertise is essential.** Children's services practitioners often lack training and expertise in understanding the risks and behaviours associated with offending. Access to criminal justice expertise, including probation and specialist police teams, is vital for informed risk assessment and planning. Safeguarding partners should consider the inclusion of appropriately experienced criminal justice practitioners within multi-agency child protection teams.

**Information sharing needs to be proactive and purposeful.** Effective safeguarding depends on timely and accurate information sharing. Practitioners should not rely solely on offenders to disclose relevant details. Instead, systems should be strengthened to ensure that information about an offender's relationships, children and risk factors is routinely shared across agencies.

**MAPPA should prioritise child safeguarding.** Child protection should be seen as core business for MAPPA, including at Level 1. Practitioners require clear guidance, local audit processes and dedicated space for inter-agency reflection focused on children's safety.

**The voluntary sector can play a key role.** Voluntary organisations can offer restorative, relationship-based support that complements statutory services. Practitioners should consider how these services can be integrated into safeguarding plans, especially when engagement with statutory agencies is limited.

3 Sexual Offences Act 2003, chapter 42, available at: www.legislation.gov.uk/ukpga/2003/42/contents

# Domestic abuse

Domestic abuse remains one of the most significant risks of serious harm to children and young people. The Panel's most recent annual report (Annual Report 2023 to 2024) found that in nearly half of cases where a child died or was seriously harmed, domestic abuse was identified within the household, particularly affecting babies under 12 months.[4] The Domestic Abuse Act 2021 and the Tackling Domestic Abuse Plan introduced reforms to police practice, recording systems and multi-agency co-ordination.[5] Importantly, the Act now recognises children as victims in their own right if they see, hear or experience domestic abuse, a change reflected in statutory guidance Working Together to Safeguard Children.[6]

While these reforms are beginning to show impact, cultural and behavioural change takes time, especially around coercive control, which remains poorly understood. Sustained, multi-agency leadership is essential to embed evidence-led practice and improve communication between adult and children's services. Supporting victims, particularly where coercive control is present, requires co-ordinated risk assessment and response through mechanisms like multi-agency risk assessment conferences (MARAC), which play a vital role in identifying hidden vulnerabilities. Practitioners need tools, training and reflective spaces to engage meaningfully with families, anticipating vulnerability and integrating adult and child safeguarding responses. Without such co-ordination, families can be left isolated and unsupported, increasing risks to children.

4 Child Safeguarding Practice Review Panel, 'Child Safeguarding Practice Review Panel: annual report 2023 to 2024', (2024), available at: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2023-to-2024

5 Domestic Abuse Act 2021, chapter 17, available at: www.legislation.gov.uk/ukpga/2021/17/contents; Home Office, 'Tackling Domestic Abuse Plan', (2022), available at: www.gov.uk/government/publications/tackling-domestic-abuse-plan

6 HM Government, 'Working Together to Safeguard Children', (2023), available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

## Key learning for practitioners: domestic abuse

**Domestic abuse should be recognised as a core safeguarding concern.** It is a significant risk factor in cases of serious harm or child death, particularly where patterns of coercion and control are present. Practitioners need to treat domestic abuse as central to child protection, not peripheral.

**Non-engagement may be a trauma response.** Victims of domestic abuse may not engage with services due to fear, trauma or complex relational dynamics. This should not be interpreted as lack of consent or absence of risk. Systems should anticipate and respond to persistent lack of engagement with empathy and persistence.

**Coercive control can obscure vulnerability.** Victims may present as confident or deny abuse, masking their vulnerability. Professionals should look beyond surface behaviours and consider the broader context of trauma, isolation and control.

**Multi-agency co-ordination is essential.** Effective safeguarding requires collaboration across children's services, police, health and domestic abuse specialists. MARACs and MAPPA need to be used proactively, especially when serious harm has occurred or been legally established.

**Specialist expertise is needed to interpret complex dynamics.** Relationships involving mutual harm, denial or minimisation require nuanced understanding. Practitioners should seek expert consultation to assess risk and formulate appropriate responses.

**Support needs to be accessible and sustained.** Offers of help should be tailored to the victim's capacity to engage. Services should be trauma-informed, culturally sensitive and persistent, recognising that achieving safety and change takes time.

**Case transfers should retain critical information.** Domestic abuse concerns need to be clearly documented and transferred between agencies to avoid loss of insight and risk escalation.

# Families who move

A more formalised and transparent approach is essential for transferring information and determining local authority accountability when families known to safeguarding agencies move between areas. The statutory duty to safeguard and promote a child's welfare lies with children's social care based on the child's usual residence, but when residency is unclear, such as during frequent relocations, accountability can become ambiguous. Data from the Panel's Annual Report 2022 to 2023 highlight that safeguarding partners often face challenges when families with multiple vulnerabilities, such as being young parents, unstable housing, and having limited support networks, move across geographical boundaries.[7] These complexities increase the risk of losing critical safeguarding information during transfers.

Moves involving families with child protection concerns require timely and comprehensive transfer of records, including court documents, social care files, health and education plans, and police involvement, alongside multi-agency insights into risks and support needs. Delays or incomplete case histories can obscure the nuances of children's circumstances, while brief summaries can fail to convey the complexity of risk. Agencies should recognise frequent moves as a potential risk factor, explore underlying causes and develop shared plans to mitigate concerns. Maintaining accessible, up-to-date chronologies and assessment summaries enables swift inter-area co-ordination. Clear protocols and local arbitration mechanisms are needed to resolve disputes about responsibility, particularly where concealed pregnancies or high vulnerability is involved, ensuring timely information sharing and safeguarding oversight.

## Key learning for practitioners: families who move

**Frequent moves can signal risk.** Repeated relocations, especially during pregnancy or while subject to child protection processes or court orders, may indicate attempts to evade agency oversight. Moves should be treated as a potential safeguarding concern, not just a logistical change.

**Transfers should be formal, multi-agency and well-documented.** Poorly managed transfers between local authorities can result in the loss of critical safeguarding information, professional insight and continuity of care. Inter-area meetings should be convened promptly, with clear decisions about accountability and case ownership.

7 Child Safeguarding Practice Review Panel, 'Child Safeguarding Practice Review Panel: Annual Report 2022 to 2023', (2024), available at: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2022-to-2023

**Supervision orders require joint oversight when families move.** Legal responsibility may remain with the originating authority, but both areas need to collaborate to ensure effective monitoring and risk management. Failure to do so can result in missed opportunities to intervene.

**Safeguarding systems should anticipate 'flight' behaviour.** Where families have a history of moving and safeguarding concerns exist, agencies should proactively plan for future moves. This includes having up-to-date chronologies, assessment summaries and agreed contingency plans in readiness for the next move.

**National alert systems need clarity and consistency.** The informal continuation of discontinued systems (for example, national maternity alerts) created confusion and false assurance. Health agencies need to follow the NHS Safeguarding Missing Person Protocol for health (publication pending) and ensure pre-birth child protection plans are recorded in Child Protection Information System (CP-IS) and shared care records.

**Unborn infants are especially vulnerable.** When pregnancy is suspected but unconfirmed, and families are mobile, safeguarding responsibility can become ambiguous. Clear protocols are needed to determine which area holds accountability for oversight and how concerns are escalated.

**Information should be accessible and transferable.** 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.

# Recommendations

The national review sets out recommendations for government, local safeguarding partners and inspectorates to act on.

## Protecting babies and unborn infants

National recommendation:

1. The next version of Working Together to Safeguard Children should include a new section on safeguarding and child protection for babies, which includes content on vulnerable babies, concealed pregnancy and pre-birth planning for unborn infants when there are child protection risks.

Recommendations to safeguarding partners in England:

2. Safeguarding partners should have a multi-agency pre-birth protocol for unborn infants that includes concealed pregnancy, with a focus on vulnerable babies, when there are child protection risks.
3. Safeguarding partners should review the quality, robustness and consistent implementation of pre-birth protocols to ensure practice and delivery is in line with 'Born into Care: Best practice guidelines for when the state intervenes at birth'.[8]

## Engaging parents

National recommendations:

4. The next version of Working Together to Safeguard Children should make clear that safeguarding partners need to work with all relevant adult services to develop, implement and resource effective parental engagement strategies. This should include developing, implementing and resourcing effective multi-agency parental support planning when parents are no longer able to care for their children. The aim is to reduce the risk of further children being removed from parental care and to promote consistency in local area approaches. The government should keep under review whether these requirements need to be further strengthened in primary legislation.

8 Nuffield Family Justice Observatory, 'Born into Care: Best practice guidelines for when the state intervenes at birth', (2023), available at: www.nuffieldfjo.org.uk/wp-content/uploads/2023/03/nfjo_newborn-babies_best_practice_guidelines_english_20230330-2.pdf

5. The next version of Working Together to Safeguard Children should include a definition of trauma on which safeguarding partners, agencies and organisations can base their approaches to trauma-informed practice, with reference to the government's working definition of trauma-informed practice.[9]

Recommendations to safeguarding partners in England:

6. 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)

7. 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.

8. 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.

9. 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.[10]

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9 Office for Health Improvement and Disparities, 'Working definition of trauma-informed practice', (2022), available at: www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

10 Office for Health Improvement and Disparities, 'Working definition of trauma-informed practice', (2022), available at: www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

## Serious offenders

National recommendations:

10. 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.
11. The 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.
12. Working Together to Safeguard Children should reflect the HMPPS Child Safeguarding Policy Framework, which requires all Heads of Probation Delivery Units to attend local safeguarding partnership meetings where required.
13. Working Together to Safeguard Children should 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.[11]

Recommendations to safeguarding partners in England:

14. 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.
15. 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.
16. 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 knows how to make MARAC referrals.

11 MAPPA, 'Membership of the SMB', available at: https://mappa.justice.gov.uk/MAPPA/viewCompoundDoc?docid=15831860&partid=15832084&sessionid=&voteid=

## Families who move

National recommendations:

17. The next version of Working Together to Safeguard Children should:

    a. 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; this should include a full case summary and chronology for the transfer-in conference relating to that child and family that adheres to the timescales set out in Working Together to Safeguard Children for child protection and 'children in need'[12]

    b. 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

Recommendations to safeguarding partners in England:

18. Safeguarding partners should ensure that, where practitioners are concerned for the welfare of a missing pregnant woman and her unborn infant, 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.

19. 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.[13]

**Action for inspectorates:**

20. Ofsted, the Care Quality Commission, HM Inspectorate of Constabulary and Fire & Rescue Services, HM Inspectorate of Probation and HM Inspectorate of Prisons for England and Wales should consider and act on the findings of this review and revise inspection frameworks accordingly.

12 For the purpose of the review, 'children in need' refers to children defined under section 17 of the Children Act 1989, including children whose health or development would be adversely affected without support, or who are disabled. See Children Act 1989, Section 17, available at: www.legislation.gov.uk/ukpga/1989/41/section/17

13 HM Government, 'Working Together to Safeguard Children', (2023), available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

Protecting vulnerable babies better demands a deliberate shift from reactive responses to proactive, relational and trauma-informed safeguarding. This means anticipating risk for unborn infants, sustaining post-removal support for parents beyond statutory timescales, and embedding multi-agency collaboration at every level. These changes require sustained commitment, co-ordination and investment across safeguarding partners. As we have emphasised above, the responsibility for Victoria's tragic death lies solely with her parents and was the result of their criminal actions, but the lessons from her short life belong to everyone with a role in child protection and safeguarding. Implementing the recommendations in this review is essential if we are to help prevent future harm and ensure that no baby remains unseen or unsupported.

# 1. Introduction

## Background

This national review was prompted by the death of baby Victoria Marten, who was born in late December 2022 and whose body was discovered by police on 2 March 2023. Her parents, Constance Marten and Mark Gordon, were subsequently convicted of gross negligence manslaughter, child cruelty, perverting the course of justice and concealing the birth of a child. The Panel's decision to undertake a national review was informed by the findings of the initial rapid review, which identified key themes of wider systemic importance requiring further examination.

In addition to learning for children's safeguarding systems, this review also identifies learning for all relevant adult services and Safeguarding Adults Boards. The circumstances surrounding Victoria's death highlight the need for co-ordinated responses that address both child and adult vulnerabilities, particularly where trauma, domestic abuse and escalating risk are present.

While the combination of circumstances leading up to Victoria's tragic death were rare and unusual, the professional challenges encountered in the years, months and weeks leading up to her birth and untimely death are not.

## Key themes the review identifies

- Persistent non-engagement: across all pregnancies, the couple avoided assessments and withheld critical information.
- Concealed pregnancies: at least three pregnancies were concealed or disclosed late, limiting safeguarding opportunities.
- Domestic abuse is a core safeguarding concern and should be central to multi-agency child protection planning.
- Cross-border movement: frequent relocations disrupted continuity of care and complicated statutory oversight.
- Escalating risk: each subsequent pregnancy involved greater concealment and disengagement, culminating in Victoria's death.
- Limited assessment opportunities: despite repeated proceedings, professionals were unable to complete robust assessments of parenting capacity or psychological needs.
- Multi-agency co-ordination is essential when working with an individual who has a history of serious offending.

These issues are reflected in numerous rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) that are received by the Panel and present significant challenges for safeguarding agencies. These complex issues warranted further analysis and consideration through this national review.

Much detail regarding the backgrounds and lives of Victoria's parents, Constance Marten and Mark Gordon, is already in the public domain. The purpose of this review is not to repeat the criminal trials that have already happened but rather to identify learning that can strengthen multi-agency safeguarding practice in the future. It draws on the learning gained from considering and understanding Victoria's family circumstances alongside wider evidence from other reviews of serious child safeguarding incidents and relevant research.

It is important to acknowledge how much skilled and dedicated work was undertaken with Victoria's family by professionals across all agencies. Without exception, the review heard thoughtful and open reflections from all professionals involved. Professionals who directly contributed to this review brought a clear and shared commitment to reflect on and learn from what happened to Victoria and to her family, and we are grateful to them all.

The review does not speculate on whether different actions would have changed the outcome. We are mindful of the bias of hindsight, and this review does not claim, nor is it possible to know, whether any of our recommendations would have made any difference to Victoria's life. Responsibility for Victoria's death lies solely with her parents. Our focus is on what can be learned to improve future practice so that we can all protect vulnerable babies better, both in utero and during their first years of life.

We are very grateful to all of those who have dedicated their time, expertise and perspectives to shape this national review.

In gathering information about Victoria's life and the involvement of key agencies with her and her family, we conducted 43 interviews with approximately 53 professionals. Three workshops were attended by professionals who were involved and worked with Victoria's family. We also benefited greatly throughout the review period from the consistent support and challenge from the children's safeguarding partnership in LB2.

Roundtables were held with representatives from specific sectors to discuss the findings and inform the recommendations put forward in this review.

The Panel would particularly like to thank the appointed reviewer, Anna Racher, who reviewed the research, undertook the extensive fieldwork and completed the analysis that led to the review findings.

# Key learning for practitioners

The following learning points summarise the core themes identified through this national review. They reflect cross-cutting practice challenges and system-wide insights relevant to both children's and adult safeguarding services.

Professionals working with Victoria's family encountered all too familiar challenges in engaging parents where there were known risks. Far beyond Victoria's family circumstances, effective engagement with parents is fundamental for agencies who are working to understand the likelihood of harm to current and future children within a family. That is why a key finding of the review is the need for the child protection system to recognise and respond better to the impact of trauma, whether past or current, on parental engagement.

It is evident of course that only a very tiny number of parents who come to the attention of agencies will commit anything like the awful criminal offences that we saw in Victoria's life and death, but many more of those same parents will have experienced considerable trauma in their lives and will be grappling desperately with the continuing impacts of that trauma. Trauma that is inevitably made even worse if their children are then removed from them, however right that decision to remove may be. Trauma that can often only be made bearable by bringing another baby into the world. We must understand and engage better with these realities of human experience, choices, reactions and suffering if we are to stop these cycles of risk and harm from repeating themselves in the future and change lives for the better.

Research shows that trauma can significantly affect an individual's ability to recognise and respond to threats and support. Parents who have experienced trauma often face greater challenges in establishing trust with professionals.[14] In addition to historic trauma, evidence from rapid reviews and LCSPRs submitted to the Panel shows that parents involved in serious incidents are also more likely to be struggling with 'known' poor mental health, domestic abuse and substance use.[15]

Practitioners working within the children's safeguarding system therefore need to understand trauma and how its intersection with other vulnerabilities may shape parental behaviour. Trauma-informed responses should be collaboratively developed and offer flexibility to help parents feel safe enough to engage, while maintaining a clear focus on the child's welfare.

14 Jill Levenson, 'Trauma-Informed Social Work Practice', (2017), available at: https://academic.oup.com/sw/article-abstract/62/2/105/2937786; Sheena Webb, 'The Toxic Trio, Adverse Childhood Experiences and the Family Court', (2021), Seen and Heard, 31(2), available at: www.nagalro.com/_userfiles/pages/files/sheena_webb_articlejs.pdf

15 Child Safeguarding Practice Review Panel, 'Child Safeguarding Practice Review Panel: Annual Report 2023 to 2024', (2025), available at: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2023-to-2024

Where parents are not engaging, the system should adopt a structured, multi-agency problem-solving approach. This includes drawing on the widest possible professional expertise across domestic abuse, mental health, substance use and offending behaviour to analyse available information, including what is not known. This process is distinct from information sharing alone; it requires shared interpretation and co-ordinated action; and it may require significant input and support from services for adults, not just services for children. Support for parents who have experienced trauma should be long-term and relational, and it may need to continue outside the immediate child protection process. While the child's safety remains the overriding priority, work with parents may need to continue long after proceedings have ended to reduce future risk and promote sustainable change. This includes anticipating and preparing for future pregnancies, which may be concealed.

Rapid review and LCSPR data related to concealed pregnancy is included in this review and shows how the concealment should be considered alongside contextual information as a serious safeguarding concern, particularly where previous concealed pregnancies and/or removals have occurred. Reasons for the concealment should be considered, including whether this represents a deliberate attempt by parents to avoid further legal proceedings and loss. This behaviour may reflect deep trauma, grief and mistrust of services. Where pregnancy is known, the importance of pre-birth planning to establish trust, support engagement and promote safe preparation for the birth is paramount. In Victoria's situation, professional foresight was needed not only before her birth, but even before her conception, to maximise the chances of keeping her safe. Given the family history, practitioners needed to contemplate the prospect of Victoria being conceived and born well in advance, to have a better chance of engaging more productively with her parents.

The review found that often children's social care and offender management agencies work in isolation, leading to critical information regarding the vulnerability of parents and/or children not being fully understood. These agencies need to work collaboratively together at both a strategic and an operational level, to ensure that policy and practice both work to keep children protected. Additionally, we found that practitioners working in child protection often lack specialist expertise to enable them fully to comprehend the risks that may be associated with offenders. This gap in understanding needs to be mitigated by safeguarding partners having access to specialist offender management expertise within their teams.

Finally, the review considered the challenges associated with families who require the support of agencies and who move across local authority boundaries. The review found that, particularly where moves were transient, the duty to protect children can open debate as to which local authority holds accountability and how concerns are escalated. Evidence from our data shows that the transfer of key safeguarding information often does not occur in a timely manner, with documentation often also being incomplete. Poorly managed transfers between local authorities can result in the loss of critical safeguarding information, vital professional insights and continuity of care. In the most serious cases they can also lead to missed opportunities to protect children.

In response, the review put forward the recommendations below for government, local safeguarding partners and inspectorates to act on.

# Recommendations

## Protecting babies and unborn infants

National recommendation:

1. 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 infants when there are child protection risks.

Recommendations to safeguarding partners in England:

2. Safeguarding partners should have a multi-agency pre-birth protocol for unborn infants that includes concealed pregnancy, with a focus on vulnerable babies, when there are child protection risks.
3. Safeguarding partners should review the quality, robustness and consistent implementation of pre-birth protocols to ensure that practice and delivery is in line with 'Born into Care: Best practice guidelines for when the state intervenes at birth'.[16]

16 Nuffield Family Justice Observatory, 'Born into Care: Best practice guidelines for when the state intervenes at birth', (2023), available at: www.nuffieldfjo.org.uk/wp-content/uploads/2023/03/nfjo_newborn-babies_best_practice_guidelines_english_20230330-2.pdf

## Engaging parents

National recommendations:

4. The next version of Working Together to Safeguard Children should make clear that safeguarding partners need to work with all relevant adult services to develop, implement and resource effective parental engagement strategies. This should include developing, implementing and resourcing effective multi-agency parental support planning when parents are no longer able to care for their children. The aim is to reduce the risk of further children being removed from parental care and to promote consistency in local area approaches. The government should keep under review whether these requirements need to be further strengthened in primary legislation.

5. The next version of Working Together to Safeguard Children should 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.[17]

Recommendations to safeguarding partners in England:

6. 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)

7. 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.

17 Office for Health Improvement and Disparities, 'Working definition of trauma-informed practice', (2022), available at: www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

8. 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.

9. 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.

## Serious offenders

National recommendations:

10. 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.

11. The 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.

12. Working Together to Safeguard Children should reflect the HMPPS Child Safeguarding Policy Framework, which requires all Heads of Probation Delivery Units to attend local safeguarding partnership meetings where required.

13. Working Together to Safeguard Children should 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.[18]

Recommendations to safeguarding partners in England:

14. 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.

18 MAPPA, 'Membership of the SMB', available at: https://mappa.justice.gov.uk/MAPPA/viewCompoundDoc?docid=15831860&partid=15832084&sessionid=&voteid=

15. 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.
16. 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 knows how to make MARAC referrals.

## Families who move

National recommendations:

17. The next version of Working Together to Safeguard Children should:
    a. 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 – this should include a full case summary and chronology for the transfer-in conference relating to that child and family that adheres to the timescales set out in Working Together to Safeguard Children for child protection and children in need
    b. 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

Recommendations to safeguarding partners in England:

18. Safeguarding partners should ensure that, where practitioners are concerned for the welfare of a missing pregnant woman and her unborn infant, 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.
19. 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.

**Action for inspectorates:**

20. Ofsted, the Care Quality Commission, HM Inspectorate of Constabulary and Fire & Rescue Services, HM Inspectorate of Probation and HM Inspectorate of Prisons for England and Wales should consider and act on the findings of this review and revise inspection frameworks accordingly.

# Methodology

The review's methodology was designed to promote learning rather than assign blame, with recommendations aimed at improving support and protection for children and families. It drew on robust evidence including published research, professional insight and lived experience, and took a systemic approach examining practice across delivery, management and strategic levels, as well as intra- and inter-agency collaboration. Key organisations and stakeholders were engaged throughout to test emerging findings.

The review was conducted in four phases:

i. gathering information and evidence
ii. defining key practice themes
iii. developing findings through interviews and workshops
iv. finalising recommendations with input from sector bodies and national stakeholders

It included 43 interviews, 53 practitioner perspectives, and analysis of 41 relevant rapid reviews and LCSPRs. Further details of the methodology can be found at Annex A.

# Family background

Constance Marten and Mark Gordon had five children between 2017 and 2022. The children are of mixed heritage reflecting the parents' white British and Black British backgrounds. The family's involvement with statutory agencies began before the birth of their first child and continued across several local authorities. Only two of the children lived with their parents, and all the children were placed in care at a young age due to child protection concerns.

According to her parents, Victoria was born on 24 December 2022, when they had no fixed abode and were frequently moving locations in an attempt to avoid statutory intervention. During Victoria's short life she never had a proper home and her basic needs for safety, security and care were not addressed; consequently, Constance Marten and Mark Gordon were convicted of gross negligence manslaughter and were each sentenced to 14 years in prison, with Mark Gordon receiving an additional four years on extended licence. Practitioners involved in the care of Victoria's siblings contributed reflections to this review because the children were too young to participate directly. The review also heard directly from Constance Marten, who provided written responses to questions posed; her reflections are included in this report.

Mark Gordon and Constance Marten experienced different childhoods. Mark Gordon committed two serious offences and received a long prison sentence as a teenager in the United States, while Constance Marten reportedly came from a privileged background.

An outline chronology is detailed below. References to London Borough 1 (LB1), London Borough 2 (LB2), London Borough 3 (LB3) and Wales (W1) are included to differentiate between three London boroughs and a local authority in Wales who were all involved with the family.

| Date | Area | Incident |
|---|---|---|
| **1990** | | Mark Gordon is convicted of a serious sexual offence and battery in the USA, when he was 15. He received a 40-year sentence, to be served in the US. |
| **2010** | | Mark Gordon is deported to England after serving 20 years of his sentence. His name is placed on the Sex Offenders Register in England. The Jigsaw Team, a specialist sex offender team in the Metropolitan Police, oversaw arrangements. |
| **2016** | | Mark Gordon meets Constance Marten. The couple travel to Peru and have a 'spiritual marriage'. |
| **Feb 2017** | LB1 | Constance Marten is pregnant with her first child. A referral is made to children's social care due to concerns related to parental engagement. The couple did not engage with children's social care. |
| **Oct 2017** | W1 | Constance Marten and Mark Gordon move to W1. Unknown to services they are living in a tent on wasteland. |

| Date | Area | Incident |
|---|---|---|
| **Nov 2017** | W1 | **Sibling 1 is born in hospital.** Safeguarding concerns, including the couple giving false names and details, are escalated by hospital staff. The identity of the couple is confirmed by a 'national maternity alert'.<br>Mark Gordon assaults two female police officers, trying to abscond when police are called to hospital.<br>• Mark Gordon is arrested and sentenced to 20 weeks imprisonment<br>• an interim care order is granted to W1 |
| **July 2018** | W1 | Care proceedings conclude after 35 weeks and nine hearings. A six-month supervision order is made and designated to W1.<br>Constance Marten is pregnant with her second child. This information is not shared with practitioners in W1. |
| **Sept 2018** | LB2 | Mark Gordon, Constance Marten and Sibling 1 move to LB2. |
| **Oct 2018** | LB2 | Constance Marten books her second pregnancy directly with LB2 community midwifery. She does not share details of the supervision order or Mark Gordon's offending history with the team. |
| **Jan 2019** | LB2 | The supervision order to W1 expires. |
| **April 2019** | LB2 | **Sibling 2 is born at home.** The independent midwife has safeguarding concerns and makes a referral to children's social care. |
| **May 2019** | LB2 | A Children and Families Assessment is attempted. Constance Marten and Mark Gordon do not consent to the assessment. |
| **Aug 2019** | LB2 | Constance Marten is pregnant with Sibling 3. |
| **Nov 2019** | LB2 | Constance Marten is brought into hospital by ambulance following a fall from a first-floor window at 4am. She is pregnant and has sustained life-threatening injuries but denies domestic abuse. The third pregnancy becomes known to practitioners. Decision for a section 47 enquiry is taken by LB2. |

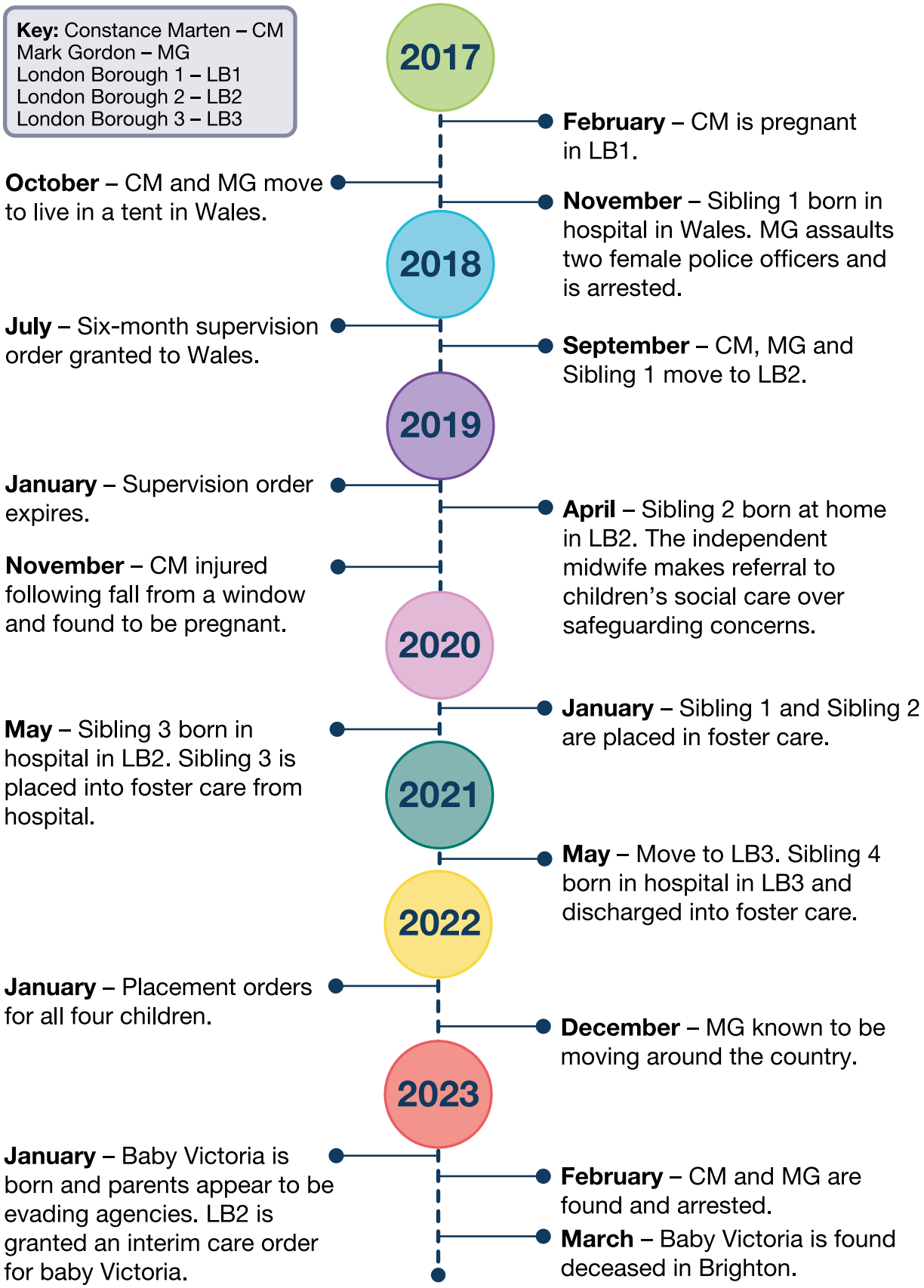
| Date | Area | Incident |
|---|---|---|
| **Dec 2019** | LB2 | Constance Marten is confirmed to be in the Republic of Ireland with Sibling 1 and Sibling 2. Mark Gordon remains in LB2.<br>Wardship proceedings in the High Court are commenced by Constance Marten's family. A recovery order is granted for the children in civil proceedings. A court order in the Republic of Ireland agrees that Constance Marten is to return to the UK. |
| **Jan 2020** | LB2 | Constance Marten and the children return to the UK. Sibling 1 and Sibling 2 are safeguarded under powers of police protection.<br>**Interim care orders are granted for Sibling 1 and Sibling 2** who are placed in foster care. A pre-birth assessment is initiated for Constance Marten's unborn infant. |
| **March 2020** | LB2 | First national COVID-19 lockdown. Contact with Sibling 1 and Sibling 2 is stopped as contact centres close. |
| **May 2020** | LB2 | **Sibling 3 is born in hospital.** LB2 is granted an emergency protection order and then an **interim care order**. Sibling 3 is placed into foster care from hospital and **care proceedings** are consolidated with those of their older siblings. |
| **Aug 2020** | LB2 | Constance Marten is pregnant with Sibling 4. This information is not shared with practitioners. |
| **Feb 2021** | LB2 | A fact-finding hearing is held in the Family Court. There is an **adverse finding of fact** made in relation to the incident of domestic abuse that had occurred in November 2019 and the threshold is deemed to be proven in relation to care proceedings.[19] The Family Court found: 'the father has behaved violently towards the mother on at least one occasion, and that his conduct on that occasion, both in causing injury, and in failing to seek medical help, put her life and the life of their unborn child at serious risk'. |

19 An adverse finding of fact in a fact-finding hearing occurs when the court determines that the allegations made by one party are true, leading to a decision that may affect the outcome of the case. Demstone Chambers, 'Family Court Fact Finding Hearings: A Guide', (2025), available at: https://demstonechambers.co.uk/family-court-fact-finding-hearings-guide

| Date | Area | Incident |
|---|---|---|
| **May 2021** | LB3 | Constance Marten confirms her fourth pregnancy to LB2 children's social care.<br>The couple have moved, so a referral is made to LB3 and the case is assigned to LB3's pre-birth team for assessment while the care proceedings for the children of the family continue. |
| | LB3 | **Sibling 4 is born in hospital.** LB3 is granted an **interim care order** in respect of Sibling 4, who is discharged into foster care. Sibling 4's case is consolidated with their siblings' care proceedings in LB2. |
| **Jan 2022** | LB2 | LB2 is **granted care and placement orders for all four children**. The parents make no direct contact with LB2 children's social care after February 2022. |
| **March 2022** | LB3 | Constance Marten is pregnant with Victoria. This information is unknown to any agency. Mark Gordon's registered sex offender signing-in requirement is the only contact available to agencies. |
| **Dec 2022** | | Information held by the Jigsaw Team reveals that Mark Gordon is known to be moving around the country. |
| **Jan 2023** | | It becomes known that **Constance Marten has given birth to Victoria**, although the location of the parents and child remain unknown. |
| | LB2 | LB2 is granted an **interim care order** in relation to Victoria. |
| **Feb 2023** | LB2 | Constance Marten and Mark Gordon are found and arrested, without Victoria, in Brighton. |
| **March 2023** | LB2 | Victoria is found deceased in Brighton. |

The following timeline summarises significant events, including pregnancies, moves between different local areas and safeguarding actions. It provides a visual overview of how repeated relocations and non-engagement disrupted continuity of care and increased risk.

**Figure 1: Key events in the family's history**



# 2. Engaging parents

This chapter explores the practice and system challenges of working to protect children when their parents are not willing or not able to engage with safeguarding agencies. Agencies across several local authorities experienced persistent challenges in engaging with Constance Marten and Mark Gordon to assess the likelihood of potential or actual significant harm to their children. Over multiple pregnancies and locations the couple avoided assessments, provided false information and failed to comply with statutory requirements. Mark Gordon did not complete a Jigsaw Active Risk Management System (ARMS) assessment or participate in probation or court-ordered psychiatric assessments.[20] An officer working within the Jigsaw team (a specialist sex offender team in the Metropolitan Police) told the review that they had never had so much contact with an offender before and not been able to make any progress.

In 2017, while pregnant with Sibling 1, Constance Marten disengaged from maternity services, and the couple did not respond to a children's social care referral in LB1. When Sibling 1 was born in W1, they gave false names and a false relationship history.

Child protection concerns resulted in a supervision order granted to W1. The couple did not fully engage with children's social care, inhibiting robust assessment of their ability to protect and meet their child's needs. Mark Gordon declined to share details about any therapeutic work he had undertaken, and the couple did not disclose their second pregnancy. Halfway through the supervision order the family moved from W1 to LB2. Following the birth of Sibling 2 in LB2, safeguarding referrals were made by concerned health professionals that were subsequently closed as the parents once again declined assessment or support.

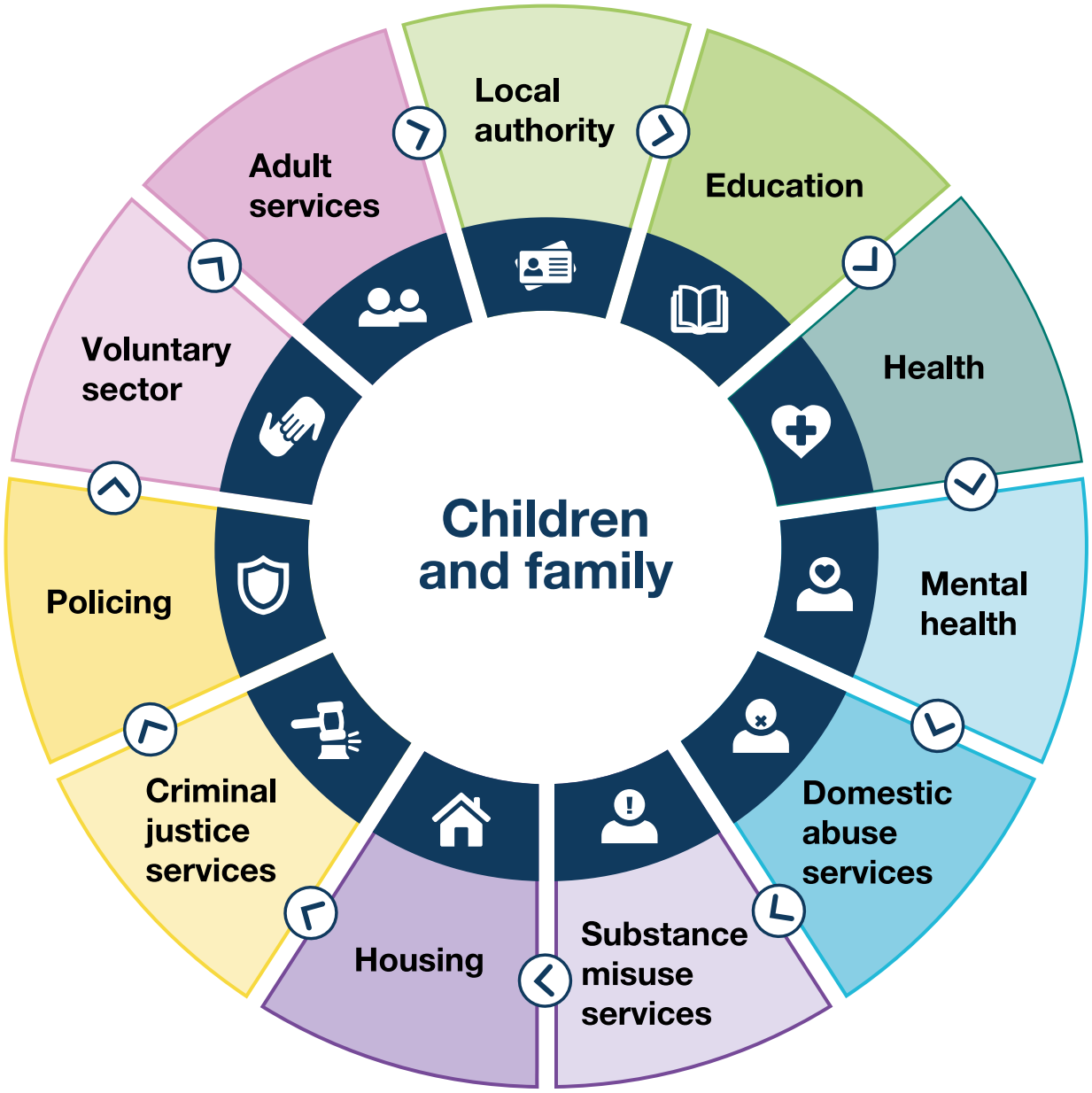
20 HM Government, 'Sex offender management and dynamic risk', (2021), available at: www.gov.uk/government/publications/sex-offender-management-and-dynamic-risk

The risk to the children escalated in late 2019 when Constance Marten, pregnant with Sibling 3, suffered life-threatening injuries during a fall, later found to have been caused by Mark Gordon. This led to care proceedings and the removal of Sibling 1 and Sibling 2 into foster care. The couple did not engage with parenting or psychological assessments, nor with pre-birth assessments for Sibling 3 and Sibling 4, both of whom were removed at birth in LB2 and LB3. After placement orders were granted for all four children, the couple ceased all contact with practitioners and concealed the pregnancy and birth of Victoria, severely limiting agencies' ability to assess risk and intervene before significant harm occurred. A local authority practitioner working with the family commented:

> "[Because] a trusting relationship just never happened, we didn't get to the heart of the issue. What stumped us all was 'why?' Why was there this lack of engagement? What does this represent? Once stuck [the focus became] how do we safeguard these children, as we can't work out capacity and engagement within the children's timeframes."

The matrix below shows how different agencies contribute to engagement strategies, from children's social care to adult mental health, probation and housing. It emphasises the importance of shared analysis and co-ordinated action rather than isolated referrals. It also illustrates how much effort may need to be put into creating an effective engagement strategy if it is to be given the best chance of working. This is challenging to achieve and hard to prioritise in our safeguarding system when so much emphasis is rightly put on keeping the child safe, but so little attention or value in comparison is given to what might make a difference to their parents. We need to confront this reality if we want to improve parental engagement, particularly in these most complex cases.

**Figure 2: A co-ordinated multi-agency approach to parental non-engagement**



# Why parental engagement matters

2.1 Safeguarding practitioners found working with Victoria's parents extremely challenging, reflecting broader difficulties faced when parents are unable or unwilling to engage with safeguarding agencies. While the circumstances surrounding Victoria's death were rare and unusual, the underlying issues are all too familiar to many professionals. When parents do not engage, practitioners struggle to gain insight into family life, understand risk and to build the relationships necessary to protect children, including those who are unborn and at risk of significant harm. Without effective engagement professionals are also not able to identify and address the support needs of key adults in the child's life.

2.2 There are multiple reasons why parents may not engage with safeguarding professionals, such as wanting to live in privacy and without interference by the state, personal histories including domestic abuse, substance use or mental ill health, previous negative experiences with public agencies, or services that do not meet their needs.

2.3 Evidence from the 'Never More Than Once: Ending repeat removals in the children's social care system' evaluation illustrates the extent of adversity experienced by parents with multiple children subject to care proceedings.[21] Among the 1,400 women Pause worked with: 87% had experienced domestic abuse, 58% reported drug use, 90% had mental health issues, 39% were care experienced, and 39% reported homelessness. These patterns are corroborated by independent evaluations, research from the University of Lancaster and the work of Philip et al. on fathers.[22]

Mothers who worked with Pause told researchers:

"Pause came into my life when I had already made a few attempts on my life. My home life was chaotic, filled with PTSD symptoms, and carrying the pain of missing my children: worrying about them, wondering if they were okay. My heart shattered each time I wondered if they were crying for their mother, and I wasn't there to give them the hugs and kisses they need."

21 Pause, 'No family should experience the removal of a child into the care system more than once', (2023), available at: www.pause.org.uk/news/no-family-should-experience-the-removal-of-a-child-into-the-care-system-more-than-once

22 Georgia Philip and others, '"When they were taken it is like grieving": Understanding and responding to the emotional impact of repeat care proceedings on fathers', (2024), Child and Family Social Work, 29(1), available at: https://research-portal.uea.ac.uk/en/publications/when-they-were-taken-it-is-like-grieving-understanding-and-respon/

"During the time I was on the Pause Programme I have taken control back of my life. My Pause Practitioner has supported me in meetings with children's services and helped me develop my communication skills, which has helped advocate for myself and my children. I have had support in building positive relationships with my children, which had broken down during a difficult time in my life. My Practitioner has helped me find who I am as a person and to see the positives in life."

2.4 Evidence analysed for this review highlights the need for a system-wide, trauma-informed approach to parental engagement. Practitioners need to be equipped with the time, skills and support necessary to build trust with parents who may be reluctant or unable to engage. At the same time practitioners need to keep in mind that, while trauma can affect parenting capacity, it does not remove the moral and legal responsibility of parents to act in their child's best interests.

2.5 Practitioners working directly with Constance Marten and Mark Gordon struggled to 'think themselves into their shoes' and to understand why they would risk having a child removed from their care rather than engage with assessments. This difficulty in understanding the couple's persistent non-engagement highlights the importance of analysing what may be driving parental behaviour. Is it a trauma response, a lack of understanding, an inability to engage or a conscious choice? Practitioners should consider if avoidance is an instinctive response to perceived threat rather than a deliberate refusal to engage. Without good engagement, a cycle can be created of escalating action and reaction between parents and safeguarding professionals (and particularly those in local authorities). This in turn can amplify rather than ameliorate parental avoidance, thereby exacerbating the potential for harm to children.

2.6 It is therefore critical to distinguish between parents who are:

- reluctant or unable to engage due to trauma
- struggling to engage for other reasons
- consciously choosing not to engage

The professional response will need to be adapted for each scenario and family. In all cases, the child's welfare remains the central concern.

Understanding the reasons for non-engagement through multi-agency discussion and information sharing, including adult services, enables a trauma-informed co-ordinated approach to be taken. This approach should identify how the service offer may need to be tailored to facilitate engagement that reflects the reasons for non-engagement. For those who choose not to engage, an assessment of the likelihood of harm will be required. Where trauma is considered to be a barrier to family engagement, plans to address the full spectrum of need should be developed through a multi-agency trauma-informed approach.

## What is trauma and trauma-informed practice?

It is important to be clear about what we mean by trauma and trauma-informed practice. The term is increasingly used across social care, health, police and other agencies, in both children's and adult's services, but the meaning can vary both between and within organisations. A shared understanding helps ensure that practitioners, leaders and agencies are aligned in their approach, and that families are clear on what this means.[23]

Trauma results from an event, series of events or a set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being.

Trauma may relate to the continuing and cumulative impact of past adverse experiences, including intervention by services – particularly statutory services and, in some cases, the (repeat) removal of children. It is inherently personal and encompasses a wide spectrum of experiences. People's responses to trauma will inevitably differ, but professionals need to seek to understand individuals' past and present life experiences and how these may be shaping current behaviours. This understanding is not just helpful, it is foundational to delivering trauma-informed care that is responsive, respectful and effective.

23 Office for Health Improvement and Disparities, 'Working definition of trauma-informed practice', (2022), available at: www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

**Key principles of trauma-informed practice**

The Office for Health Improvement and Disparities' working definition of trauma-informed practice sets out six principles of trauma-informed practice:

1. **Safety.** The physical, psychological and emotional safety of service users and staff.
2. **Trustworthiness.** Transparency exists in an organisation's policies and procedures, with the objective of building trust among staff, service users and the wider community.
3. **Choice.** Service users are supported in shared decision-making, choice and goal setting to determine the plan of action they need to heal and move forward.
4. **Collaboration.** The value of staff and service user experience is recognised in overcoming challenges and improving the system as a whole.
5. **Empowerment.** Efforts are made to share power and give service users and staff a strong voice in decision-making, at both individual and organisational level.
6. **Cultural consideration.** Move past cultural stereotypes and biases based on, for example, gender, sexual orientation, age, religion, disability, geography, race or ethnicity.

# Working towards a trauma-literate system

2.7 Building on the challenges outlined in the previous sections, the review now considers how safeguarding practice needs to evolve to better understand and respond to parental non-engagement. In the case of Constance Marten and Mark Gordon, professionals attempted to explore the impact of domestic abuse and mental health concerns, but persistent denials and the absence of in-depth assessments left them with limited insight into the couple's lived experiences. This lack of understanding potentially constrained the ability to make informed decisions about risk and intervention.

2.8 Although trauma is increasingly recognised in safeguarding practice, how it manifests itself may be less well understood. Trauma often presents through behaviours that may seem irrational or resistant but are, in fact, protective coping mechanisms. Recognising and reframing these behaviours enables practitioners to move beyond surface-level assessments and engage more effectively with families.

2.9 Importantly, trauma-informed care should not be seen as a substitute for evidence-based, trauma-specific treatments. As highlighted by 'Trauma-informed care: Understanding the use of trauma-informed approaches within children's social care', a comprehensive response requires both trauma-literate professional engagement and access to appropriate therapeutic services.[24]

2.10 Evidence from rapid reviews and LCSPRs suggests that, while professionals often recognise the risk of significant harm, they may struggle to apply trauma-informed approaches when engaging with parents who avoid or resist contact. Models such as the Family Drug and Alcohol Court (FDAC) demonstrate how structured, therapeutic interventions can support parental engagement and improve outcomes.

2.11 Ultimately, building a trauma-literate system means equipping practitioners with the time, skills and support to build trust with parents who may be reluctant or unable to engage.

24 Early Intervention Foundation, 'Trauma-informed care: Understanding the use of trauma-informed approaches within children's social care', (2022), available at: www.eif.org.uk/report/trauma-informed-care-understanding-the-use-of-trauma-informed-approaches-within-childrens-social-care

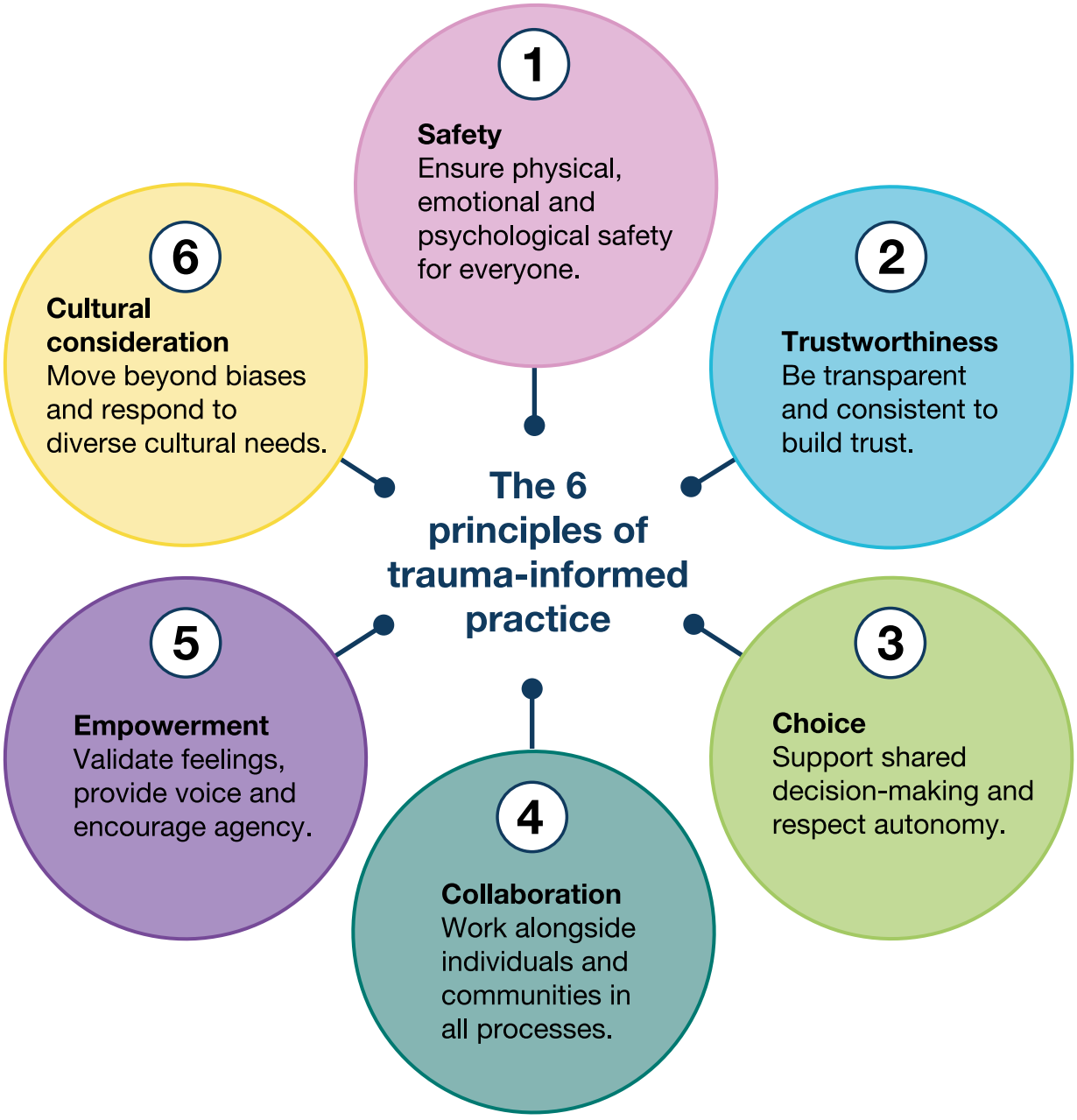
**Figure 3: Definition of trauma and trauma-informed practice**

**How do we define trauma?**

Trauma results from an event, series of events or set of circumstances that an individual experiences as harmful or life-threatening. While each experience is unique, trauma can have lasting effects on mental, physical, social, emotional and spiritual wellbeing.

**What is trauma-informed practice?**

A trauma-informed approach recognises that trauma can affect individuals, groups and communities. It increases awareness of the widespread impact of trauma, improves accessibility and quality of services, and works to prevent re-traumatisation.



# Linking trauma-informed practice to effective safeguarding

2.12 Practitioners should be mindful of how parents' past experiences, including trauma, discrimination and negative encounters with professionals, can shape their ability or willingness to engage. Building meaningful relationships with parents, especially those facing adversity, is critical to protecting children. Practitioners need to be skilled in recognising and responding to trauma, balancing empathy with accountability while remembering that children's needs remain central in safeguarding practice.

2.13 Reframing non-engagement as a possible trauma response encourages professionals to consider what might help parents feel safer and more able to trust.[25] An intersectional lens, as highlighted in 'Race, Racism and Safeguarding Children', can further support understanding of how race, class and isolation shape parental experiences.[26]

# Non-engagement must not block the system

2.14 Effective safeguarding practice relies on the ability of practitioners to make robust, evidence-based assessments, which is heavily dependent on parental engagement and disclosure. Non-engagement can become a profound blocker and, as happened with Victoria's family, result in care proceedings becoming the only option for protecting a child. Practitioners are reliant on the relationships they build with families as, unless court proceedings have been initiated, there is no legal requirement for parents to engage. Constance Marten and Mark Gordon's persistent reluctance to engage with assessments meant that practitioners struggled to gain deep insight into the family and how they might work with them.

2.15 During their second pregnancy, the couple disengaged from NHS care, advising agencies that they had made private healthcare provision. This added to the difficulty that children's social care experienced in accessing timely and relevant health information to complete their assessment of likelihood of significant harm. Information gathering is often reliant on parents disclosing relevant information or accessing NHS Primary Care health records.

25 Sheena Webb, 'The Toxic Trio, Adverse Childhood Experiences and the Family Court', (2021), Seen and Heard, 31(2), available at: www.nagalro.com/_userfiles/pages/files/sheena_webb_articlejs.pdf

26 Child Safeguarding Practice Review Panel, 'Race, racism and safeguarding children', (2025), available at: www.gov.uk/government/publications/race-racism-and-safeguarding-children

2.16 Social, racial and class bias can influence professionals away from assessing safeguarding risks for clients who are affluent, well educated, articulate and particularly socially adept. This could lead to 'affluent neglect' or wider harms being missed.[27] Constance Marten had the social aptitude and personal wealth to engage independent healthcare. The review found no evidence to suggest that practitioners across all statutory agencies were influenced by her presentation or her resources. Practitioners were found to be open, reflective and insightful regarding the potential impact that class and social privilege could have on their practice.

2.17 No specific agency was 'sitting' on information, though all key agencies were observing and articulating a pattern of 'non-engagement' by Constance Marten and Mark Gordon. What was absent was collective thinking about how to address and 'unlock' the pattern of non-engagement by parents. Apart from some initial crisis-focused strategy meetings and reviews for children looked after, there were relatively few opportunities for professionals from different agencies to develop a shared and systemic perspective on what was happening and how agencies might need to act to tackle the non-engagement.

2.18 In reference to this lack of a multi-agency forum for practitioners to come together, share information and formulate a solution to what was being observed within the family, a local authority contributor to the review commented:

"I don't believe that the system wasn't equipped, it goes back to the right people being in the room. We didn't even have a room."

2.19 Effective inter-agency practice is pivotal to the ability of safeguarding professionals to have insight into what is happening in a child and family's life. There were scant opportunities for such interagency reflection in work with Victoria's family; evidence from other child safeguarding reviews suggests that this issue has wider resonance. One LCSPR has summarised this challenge as:

"…the importance of recognising and having ways to address hidden risk when carers are not available for assessment and there is a lack of openness by carers about potentially harmful behaviours."

2.20 It is nonetheless important to recognise that the highly effective information sharing in work with this family resulted in decisions being made to initiate care proceedings to protect the four older children, to afford them safe and secure futures.

27 Claudia Bernard, 'Safeguarding children in affluent families', (2018), available at: https://www.gold.ac.uk/research/case-studies/social-work-with-affluent-families/

2.21 When engagement is challenging or not straightforward, there need to be mechanisms within the system for all agencies and professionals to take a step back and 'think slowly' together. This could seem to be an inefficient use of scarce resources but, without such 'slowing down', there is a risk of entrenched and escalating action and reaction. This is, in turn, costly, time-consuming and, most importantly, unlikely to be in the interests of children.

## Agencies working together: supporting children, supporting parents

2.22 There is a need for stronger investment and evidence about what works when supporting and helping parents where there are concerns about risks of harm to children. As Foundations has commented on their website:

"We know less about how best to support families where there are factors that can make parenting particularly difficult, including substance misuse, parental conflict, abuse and neglect, sexual abuse, emotional abuse, and parental mental health issues. There is a lack of evidence about the types of parenting support likely to be most effective in the context of some of these risks."[28]

2.23 There is a growing body of evidence on the potential of effective approaches to therapeutic interventions for trauma, yet many parents struggle to access these services due to barriers in engagement.[29] Working with parents who have experienced trauma in their lives can be very specialised work; it may also require support to help parents 'reach the bottom rung' of current specialist help and support services.

"[There is] so much prep work before even considering a referral. The gap is engagement. The bottom rung of referral pathways is too high for a family to be able to reach. They need a leg up. Their relationships have been so abused that even sitting in a room with a good practitioner elicits so much anxiety it will trigger a false, masking, presentation. It could take weeks to get past even this." (Family Drug and Alcohol Court)

28 Foundations, 'Supporting parenting', (2025), available at: https://foundations.org.uk/about-us/priority-areas/supporting-parenting/

29 Andreas Maercker and others, 'Complex post-traumatic stress disorder', (2022), The Lancet, 400(10345), pages 60 to 72, available at: www.sciencedirect.com/science/article/abs/pii/S0140673622008212

2.24 There is evidence that long-term, relational support helps parents engage with specialist services and improve outcomes. Models such as Pause, the Family Drug and Alcohol Court (FDAC), the Family Nurse Partnership and locally developed recurrent care responses prioritise trust-based relationships that begin with parents' immediate needs and build towards addressing entrenched difficulties.

2.25 Adult-focused services, such as those addressing substance use, mental health, housing and domestic abuse, are a first step to enabling families to engage with specialist therapeutic interventions, particularly when embedded within a 'Think Family' approach. This ensures that adult vulnerabilities and their impact on child welfare and parenting are understood and supported, building a foundation upon which specialist interventions can then be delivered. Trusted professionals such as GPs, midwives and health visitors are often well-placed to identify need and encourage engagement, especially where trust in other statutory agencies is low. Equipping the right professionals to signpost and advocate for trauma-informed, holistic support is essential to improving outcomes; but it also requires the whole safeguarding system to recognise this as a priority for attention and investment. The review acknowledges that the reforms being delivered through the Families First Partnership programme are seeking to embed a 'whole-family' approach throughout the children's social care system.

2.26 Sector representatives described this to the review as a "matrix of offer". This could be achieved by safeguarding partners convening local stakeholders to review existing adult and children's services, identify gaps and assess whether current services can be adapted or if additional provision is required. This should encompass the full range of services available, including adult services providing domestic abuse, mental health, substance use and housing support, for example. This could be delivered through the recent children social care reforms being rolled out through the Families First Partnership programme, which focuses on early intervention including through Family Help, multi-agency child protection and family group decision-making.

2.27 The review heard from services working with parents across England that multidisciplinary teams using practice models with these characteristics are more likely to 'hear' parents who feel marginalised and vulnerable within the child protection system:

"It feels like a maze… Being told I have a diagnosis and need therapy, but then mental health services saying I don't need support. It's confusing." (Parent accessing recurrent care support)

2.28 The review found that, when parents struggle to engage with child protection processes, it can be helpful to offer support in a distinct space where their needs and concerns can be heard. Because local authority children's social care teams are directly associated with decisions to remove children, some parents may find it psychologically impossible to trust or engage in post-removal support if this is delivered by professionals they associate with past trauma. While social workers can and do form warm relationships with parents, those who have experienced trauma may also need access to distinct, specialist support to process their experiences and rebuild trust.

When asked the question:

"In your opinion, how well do child safeguarding agencies support parents to deal with the impact of having a child removed?"

Constance Marten replied:

"Nothing was done, but I wonder whether there should be an independent and confidential service to assist parents that is separate from the local authority."

2.29 Support should begin during proceedings, not after decisions to remove children are made, to interrupt cycles of harm and reduce future risk. The most complex engagement work is necessarily slow and may not align with statutory child protection timescales, but it remains essential. Long-term preventative work is vital not only to safeguard future children but also to support parents' wellbeing and recovery.

## Key learning for practitioners: engaging parents

**Non-engagement needs to be actively understood and addressed.** Practitioners should consider whether avoidant behaviour may be rooted in trauma, rather than assuming it reflects deliberate resistance. This understanding is essential to safeguarding both current and future children.

**Trauma does not remove parental responsibility.** While trauma may affect a parent's capacity to engage, it does not negate their moral and legal duty to act in their child's best interests. This principle should remain central to safeguarding practice.

**Practice should be trauma-literate and intersectional.** Professionals need to recognise how trauma, discrimination and systemic bias may shape parental behaviour. Responses should be adapted to help parents feel safe enough to engage, while maintaining a clear focus on the child's welfare.

**Multi-agency reflection is essential.** When parents do not engage, agencies should create structured opportunities for joint reflection and shared problem-solving. Strong information sharing is not enough: there also needs to be a shared discussion space for analysis and co-ordinated action.

**Support needs to extend beyond proceedings.** Parents who have experienced trauma may require long-term, relationship-based support that continues beyond the conclusion of care proceedings. This is vital to reduce the risk of future harm and to support potential future parenting.

**Support needs to be personalised.** It may take parents years to be ready for therapeutic interventions, and support to address other presenting issues may be the more pressing priority. A spectrum of co-ordinated support should be available. It can be bespoke to what parents need and can cope with at different points in time in their individual journeys to achieve lasting change.

**Systemic responsibility matters.** Engagement should not rest solely with parents. Safeguarding services should be designed to build trust, anticipate resistance and offer practical, co-ordinated help that meets parents' needs.

**Specialist support needs to be distinct from statutory safeguarding roles.** Parents who have experienced trauma may struggle to engage with professionals they associate with past harm, particularly those involved in child removal. Safeguarding systems should offer access to separate, specialist support that enables parents to process their experiences and build trust without conflating therapeutic engagement with statutory authority.

# 3. Protecting babies and unborn infants

## Concealed pregnancy

This chapter explores the complex issue of concealed pregnancy, particularly among parents who have previously experienced the removal of children through care proceedings. It highlights the legal and ethical tension between a woman's right to bodily autonomy and practitioners' duty to safeguard unborn infants.

While no national guidance related to the statutory legal framework for pre-birth proceedings exists, many local safeguarding partners and NHS Trusts have developed detailed procedures to support professional responses. Where such guidance exists, it is generally consistent in its principles, but implementation and practice may differ. Drawing on national data, legal frameworks and findings from safeguarding reviews, this chapter calls for a trauma-informed, preventative approach to these complex issues.

Constance Marten and Mark Gordon had five children, all subject to child protection concerns. Their first two children were removed into care in early childhood. During their third pregnancy, Mark Gordon would later be found to have caused Constance Marten to fall from a window, which resulted in Constance Marten sustaining serious injuries. The couple did not engage with professionals during this pregnancy, and the third child was removed at birth. The couple remained disengaged and isolated, with no apparent support network. Practitioners focused on the likelihood of significant harm to each child, making it difficult for them to address the couple's own underlying needs and vulnerabilities. No one agency or professional had specific responsibility for supporting the couple or helping them process their likely sense of loss and grief as their children were removed from them. A local authority practitioner told the review:

> "We assess the hell out of people, get the results, then there isn't the space in the system to refer them on to deal with it. If adoption is the preferred permanency outcome, then it feels like a double whammy: the level of trauma that means we have to remove and then we're not going to invest in therapy etc. for you as it doesn't fit with timescales."

Although practitioners anticipated the potential risk of future concealed pregnancies, the couple remained disengaged and therefore effectively were unsupported.

In 2020, Constance Marten and Mark Gordon concealed a fourth pregnancy until shortly before birth. COVID-19 restrictions contributed, but it appears the concealment was a deliberate attempt to avoid further child removal. The couple had not engaged in care proceedings or any related assessments and therefore their fourth child was removed at birth.

After placement orders were granted for all four children, contact between the local authority team responsible for the children and the couple ceased from February 2022. No specialist services were available to help them to acknowledge and process any trauma or grief resulting from having multiple children removed at or soon after birth. A local authority practitioner told us:

> "[Immediately separated parents] don't want counselling and therapy. If their child is removed against their wishes, what they want is that child back. Parents want hope and reassurance. They want contact and working towards having their child back. I don't know any mums who have requested counselling [at this stage]."

Later that year, the couple concealed a fifth pregnancy, resulting in the birth and tragic death of Victoria. Did this concealment reflect the couple's response to repeated child removals and fear of further intervention, as suggested by the pattern of disengagement observed throughout their involvement with services? Could this final concealed pregnancy have been avoided if greater attention had been given at an earlier stage to finding ways to engage with the parents? If we do not ask ourselves these hard questions, then are we really doing all we can to keep vulnerable babies safe?

When asked:

> "In your opinion, how well do NHS maternity services understand and respond to the potential reasons for late disclosure?"

Constance Marten responded:

> "In my case the late disclosure was because I knew that the hospital would flag me up and contact services who wanted to remove my children. Anecdotally I know of other parents who were resistant to taking their children to hospital because of fear they would be presumed guilty until proven innocent. Whilst of course hospitals have safeguarding duties, the current stance may actually prevent parents from seeking timely medical care and thereby actually cause further harm to children.
>
> Some parents with mental health problems or disabilities are fearful of seeking antenatal care because they know that instead of being supported, the social workers will use their presentation at hospital as evidence of being an unfit parent."

Victoria's story reflects the safeguarding risks when parents disengage and conceal pregnancies, particularly in the context of unresolved trauma and systemic gaps in post-removal support. It underscores the need for co-ordinated, multi-agency support systems that anticipate vulnerability, build trust and provide sustained help beyond care proceedings.

## Key learning for practitioners: protecting babies and unborn infants

**Concealed pregnancy may be identified late in pregnancy, during labour or following delivery.** It is important for agencies to understand the background of the mother in order to support her needs.

**There is no legal duty to disclose pregnancy.** Women do not have to seek or accept any midwifery or medical care during their pregnancy or childbirth. Unassisted birth is a matter of choice and not in itself a reason for raising safeguarding concerns with other agencies. This can limit the ability of safeguarding professionals who are concerned about an unborn infant to intervene unless a pregnancy is disclosed or detected.

**Assessment of risk.** Where practitioners or agencies are concerned that the unborn infant may be at risk of significant harm, a referral is made to children's social care, who will decide whether further assessment is required to identify risk, offer support or develop a safety plan.

**Concealment occurs for many reasons and may be a trauma response, rather than avoidance.** Concealed pregnancies can be a deliberate attempt by parents to avoid further loss after previous children have been removed. This behaviour may reflect deep trauma, grief and mistrust of services.

**Concealment is a significant safeguarding indicator.** Practitioners need to view concealment as a serious safeguarding concern and consider contextual information, particularly where previous removals have been made.

**Safeguarding unborn infants requires proactive, relational work.** 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 infant, especially where there is a history of repeated child removal or trauma.

**Support should continue beyond the end of care proceedings.** The end of care proceedings should not mark the end of professional involvement. To prevent recurring cycles of harm, parents need long-term, trauma-informed support to process loss and reduce the risk of future concealment or harm. This support should also address wider emotional and practical needs, including mental health, substance misuse, housing and experiences of domestic abuse.

**Multi-agency planning needs to consider and respond to parental needs.** Formal parent support plans should be developed alongside child protection plans. These should address grief, trauma and practical needs, for example assistance with housing or addressing substance misuse. Agencies with specialist expertise including adult mental health and loss should be involved.

**Specialist services are not consistently available.** Access to post-removal therapeutic services is patchy across England. Where available, services with a strong evidence base, such as Pause or FDAC, demonstrate improved outcomes in breaking cycles of repeat removals for parents. These services often work in partnership with adult services, which is essential to addressing the full spectrum of parental needs and reducing future risk. Safeguarding partners could consider the breadth of adult and children's statutory and voluntary services currently available and consider how these can be set out and utilised effectively within a coherent parent support framework.

**Systemic gaps can escalate risk.** When post-removal support is unavailable to parents, their needs may go unmet or be overlooked. This can lead to escalating mistrust, disengagement and, ultimately, tragic outcomes.

# Safeguarding an unborn infant

3.1 Although Constance Marten had employed a private midwife during her pregnancy with Sibling 2, she gave birth at home without professional support. In England, women have the legal right to have an unassisted birth, also known as 'freebirth'. Agency practitioners therefore have 'no right' to know about a pregnancy, and a foetus has no legal rights until birth. These principles can complicate child protection decision making, as local authorities have a duty to identify families who may need additional support, assess any evidence to indicate the likelihood of harm to the unborn infant and, where required, convene a pre-birth child protection conference. Balancing maternal autonomy with the need to protect a vulnerable infant is a significant challenge.

3.2 The complex issue of concealed pregnancy is evidenced in rapid reviews and LCSPRs considered by the Panel. Concealment of pregnancy may arise from a range of factors, including fear of domestic abuse, cultural pressures or past trauma. Other contributing factors may include the mother being very young, having diminished capacity, conceiving through rape or an abusive relationship, or experiencing risks within her relationship or wider familial or cultural context. It is often linked to previous child removals, where disclosure is perceived as increasing the risk of separation. In such cases, parents may hide a pregnancy in the hope of keeping the child. For professionals, non-disclosure signals high risk and should prompt sensitive exploration of the underlying factors.

# No right to know: anticipating concealment

3.3 Local NHS and safeguarding partners typically distinguish between concealed pregnancy (the woman knows she is pregnant but chooses not to disclose this), denied pregnancy (the woman is unable or unwilling to accept she is pregnant) and unknown/undiagnosed pregnancy (the woman is unaware of the pregnancy until labour or birth).

3.4 Understanding and assessing risk in concealed pregnancy is complex. While many local safeguarding partners have developed their own pre-birth guidance, there is no national framework available. The 'Born into Care: Case Law Review' outlines the legal basis for pre-birth assessments, noting that the Children Act 1989 applies only after birth.[30] Working Together to Safeguard Children offers limited statutory guidance for pre-birth work. The 'Best practice guidance: Support for and work with families prior to court proceedings' acknowledges the importance of pre-birth assessments in pre-proceedings but provides no specific practice guidance on that topic.[31] The 'Born into Care: Best practice guidelines for when the state intervenes at birth' is a useful starting point for safeguarding partners to use when reviewing and developing pre-birth protocols.[32]

30 Mary Ryan and Rachel Cook, 'Born into care: case law review', (2019), available at: www.nuffieldfjo.org.uk/resource/born-into-care-case-law-review; UK Parliament, 'Children Act 1989', (1989), available at: www.legislation.gov.uk/ukpga/1989/41/contents

31 Public Law Working Group, 'Best practice guidance: Support for and work with families prior to court proceedings', (2021), available at: www.judiciary.uk/wp-content/uploads/2021/03/Prior-to-court-proceedings-BPG-report_clickable.pdf

32 Nuffield Family Justice Observatory, 'Born into Care: Best practice guidelines for when the state intervenes at birth', (2023), available at: www.nuffieldfjo.org.uk/wp-content/uploads/2023/03/nfjo_newborn-babies_best_practice_guidelines_english_20230330-2.pdf

3.5 Panel evidence from rapid reviews and LCSPRs shows that concealed pregnancy is often poorly defined. Many serious incident notifications involve 'denied' or 'unknown' pregnancies, although limited distinction between the terms is recorded. Local reviews struggled to identify significant practice learning from incidents as there had been little or no professional contact with the mother during pregnancy. However, many concealed pregnancy notifications evidenced that either the mother or her family were known to services for other risks and vulnerabilities. These included previous concealed pregnancies or late bookings, highlighting greater potential for preventative safeguarding than initially assumed.

3.6 The circumstances of Constance Marten's pregnancies highlight the extreme vulnerability of an infant in utero and as a newborn. What happened to Victoria illustrates the legal and safeguarding tension between a woman's right to experience pregnancy and childbirth free of any medical intervention and the local authority's duty. This duty includes the identification of families' support needs to address any risk of harm, or planning for the child's birth which, through assessment, decides on any action that should be taken on the child's birth to protect them.

3.7 'Mothers in recurrent care proceedings: New evidence for England and Wales' found that around a quarter of mothers involved in initial care proceedings in England and Wales return to court within ten years, either with the same or a new child.[33] This evidence reflects what happened to Constance Marten. It highlights the importance of recognising and responding to the risk of concealed pregnancy, particularly where there has been previous child removal. As the protection of an infant in utero is dependent upon a level of trust and engagement with a mother, early, relational work with women, especially those who have experienced child removal, is crucial. Concealment may reflect trauma, grief or mistrust; therefore, support should continue beyond child protection proceedings, meet parent needs, build trust and usually involve practitioners who have not facilitated the removal.

3.8 This support should be multi-agency, sustained over time and anticipate evolving parental needs. Efforts to locate vulnerable pregnant women to conduct welfare checks on their unborn infants can raise ethical tensions, particularly where they conflict with a woman's right to privacy. This highlights the importance of taking a trauma-informed, preventative approach.

33 Nuffield Family Justice Observatory, 'Mothers in recurrent care proceedings: New evidence for England and Wales', (2022), available at: https://www.nuffieldfjo.org.uk/resource/mothers-in-recurrent-care-proceedings-new-evidence-for-england-and-wales

3.9 The review asked Constance Marten:

"In your opinion, how well do child safeguarding agencies understand the impact that having a child removed can have on parents?"

Constance Marten said:

"Not at all, the LA see their role as complete once removal is achieved. In fact people can be supported and can change which should result in children being returned and supported.

Attending a contact centre is one of the most painful experiences for a parent to endure. However, there was no support when leaving the contact centre despite the obvious distress that this would cause the parents. Social workers did not seem to appreciate that this, as well as being distressing for the children, was very emotionally challenging for the parent."

3.10 The articulation of a well-thought through multi-agency 'parent support plan' can help address these risks. Parent support plans should focus on identifying vulnerabilities, acknowledging past loss and outlining the support needed following proceedings. They offer safeguarding agencies an opportunity to reflect on the impact of unmet parental needs, particularly in relation to future pregnancies. Including this information in health records can ensure continuity of care and inform future safeguarding responses. Adult services (including as necessary domestic abuse, mental health, substance use and housing support) should play a central role in these plans, ensuring that parents receive holistic, co-ordinated help that addresses both emotional and practical needs.

3.11 Safeguarding practice needs to anticipate the potential for future pregnancies, especially where there is a history of child removal. As we have noted throughout this review, parents in these circumstances are often highly vulnerable and require early, co-ordinated, trauma-informed support to reduce the risk of concealment and improve outcomes.

# Shifting thinking and practice: preventing concealment in relation to recurrent care proceedings

3.12 Victoria's concealment should be understood within the wider context of repeat removals and the trauma they cause. There is currently no national dataset linking concealed pregnancies with recurrent care proceedings, and data on pre-birth assessments and concealment remains limited.[34]

3.13 While Constance Marten and Mark Gordon's decision to conceal pregnancies may represent a more drastic response to having children removed, their actions reflect broader patterns of behaviour and vulnerability identified in research on recurrent removals. 'Recurrent care proceedings: five key areas for reflection from the research' notes:

> "the qualitative evidence from the studies looking at recurrence (Broadhurst et al. 2017; Alrouh, Broadhurst and Cusworth 2020; Philip et al. 2021) indicates that mothers and fathers who experience recurrent care proceedings share many characteristics with each other and with other vulnerable parents who are involved in care proceedings, they have experienced significant and multiple adverse experiences in their own childhoods."[35]

3.14 Parental coping strategies will vary from individual to individual, but the successive removal of Constance Marten and Mark Gordon's children may have reinforced their perception of harm caused by children's social care, making the concealment of Victoria feel subjectively 'rational'. We know that this can occur as a result of complex forces involving the parents own childhood trauma, the trauma of further loss, and the shame and isolation of disenfranchised grief (Doka, 1989) involved in losing a child to care.[36] These factors can reinforce and escalate maladaptive behaviours. We also know that, as safeguarding concerns increased, the couple's non-engagement and concealment escalated. We have to confront these realities if are to learn from Victoria's life and death and keep vulnerable babies safer in the future.

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34 Nuffield Foundation, 'Study reveals link between childhood in care and mums who have babies removed by the courts', (2017), available at: www.nuffieldfoundation.org/news/study-reveals-link-between-childhood-in-care-and-mums-who-have-babies-removed-by-the-courts

35 Nuffield Family Justice Observatory, 'Recurrent care proceedings: five key areas for reflection from the research', (2021), available at: www.nuffieldfjo.org.uk/resource/recurrent-care-proceedings

36 K.J. Doka, 'Disenfranchised grief: Recognizing hidden sorrow', (1989), Lexington Books.

3.15 Supporting vulnerable parents through loss requires specialist skills and services. The Nuffield Family Justice Observatory recommends:

> "Evidence of a heightened risk following a first repeat appearance suggests that the best solution to the possible pattern of repeat proceedings once a child has been removed would be to offer all parents in that situation intensive and tailored support to rebuild their lives. A universal entitlement to continuing help from specialist adult-focused services would be the best way forward."[37]

3.16 Although LB2 recognised the need for specialist support, none was available locally for Constance Marten and Mark Gordon after their children were removed. Their underlying vulnerabilities and mistrust of the system therefore remained unaddressed.

> "For mothers and fathers who are involved in recurrent care proceedings, the pattern of adverse experiences throughout childhood and into adulthood means that many of them are dealing with complex and unresolved trauma, which is then compounded by the trauma of having their children removed through care proceedings. The impact of such trauma and adversity often also leads to parents falling through the nets of support and being seen as 'hard to reach' or 'difficult to engage'."[38]

3.17 There is no statutory duty to provide services for families who have experienced recurrent child loss, yet access to trusted, long-term support, which is available when people are ready to engage with it, is vital to prevent future harm. Where available, these services demonstrate that multi-agency, holistic support can reduce future risk and improve outcomes for both parents and children.

37 Nuffield Family Justice Observatory, 'Mothers in recurrent care proceedings: New evidence for England and Wales', (2022), available at: www.nuffieldfjo.org.uk/resource/mothers-in-recurrent-care-proceedings-new-evidence-for-england-and-wales

38 Nuffield Family Justice Observatory, 'Recurrent care proceedings: five key areas for reflection from the research', (2021), available at: www.nuffieldfjo.org.uk/resource/recurrent-care-proceedings

3.18 Currently, support and care following removal follows the child, and not the parent. If a parent loses a child to care, there is a real risk in leaving them alone with the tremendous grief that losing a child holds, coupled with their still unmet and often overwhelming needs. The circumstances that led to the removal will not stop a parent from grieving the loss of their child and we are only fooling ourselves if we think that is not the case. This rupture needs to be repaired to interrupt the cycle of harm and achieve long-term change. As we have noted above, supporting the parents should have multiple benefits: supporting them to achieve lasting change, protecting the future child not yet even conceived and reducing the likelihood of future children needing to be removed or brought into care. If we are serious about supporting long-term transformational change, then we must all develop this wider gaze and focus on what support the parents need and keep future unborn children in mind with just as much energy as we currently devote to protecting the child who has been removed.

3.19 Concealed pregnancy, especially in the context of recurrent care proceedings, demands a shift in safeguarding practice. The case of Constance Marten and Mark Gordon, like many other cases that have come to the attention of the Panel, demonstrates how unresolved trauma, systemic gaps and lack of post-removal support can lead to tragic outcomes for babies and whole families. Practitioners should move beyond reactive responses and adopt proactive, relational approaches that anticipate vulnerability and build trust if we are to protect vulnerable babies better.

3.20 To prevent future harm, safeguarding systems need to integrate adult-focused services into their matrix of support for parents who have had their children removed, ensure continuity beyond proceedings and embed trauma-informed care across agencies. National guidance and equitable access to specialist and responsive services are essential to support both parents and unborn infants effectively.

# 4. Managing child protection risks associated with serious offenders

This chapter explores the intersection between serious offending and child protection. Mark Gordon, a UK national, moved to America in 1986, aged 12, to live with his mother and sister. In 1990, when he was 15 years old, he was convicted of a serious sexual offence and battery and sentenced to a 40-year custodial sentence in an adult jail. Mark Gordon served 20 years before his release and deportation to the UK in 2010, having spent the rest of his childhood and early adulthood in custody.

An individual who is released before the end of their custodial sentence for a serious sexual or violent offence in the UK would usually be released with licence conditions overseen by the Probation Service. However, this is not the case for UK nationals who have been deported back to the UK before serving their full prison term abroad, as licence conditions cannot be imposed in these circumstances.

On his return to the UK, as a registered sex offender, Mark Gordon was not required to share details about new partners or pregnancy. Therefore, the ability of his case officers to fully assess and put in place actions to negate the risk of harm to others was significantly inhibited.

Two critical incidents: arrest at birth (2017) and serious injury (2019), illustrate missed opportunities for inter-agency safeguarding. More effective MAPPA arrangements should have ensured that information regarding these escalating concerns was shared between agencies to strengthen the assessment of risk, for example related to domestic abuse and non-engagement.

## Key learning for practitioners: serious offenders

**Child protection and offender management should be integrated.** Serious offenders who are parents or carers pose complex risks to children. These risks are often not fully understood and can be underestimated when child protection and offender management systems operate separately. 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.

**MAPPA Level 1 management has limitations.** The most serious offenders are supervised at Level 2 or 3, but the majority of those assessed as serious offenders are supervised at Level 1. Management at Level 1 includes multi-agency support, and there is still a legal duty to share information, to work together and to assess risk. In complex cases, where there is concern about gaps in an offender's risk-management plan that impact on child safeguarding, MAPPA Level 2 meetings can bring in additional, formal multi-agency oversight. This can be helpful even where children's services are already involved.

Under the Sexual Offences Act 2003, RSOs must notify police of travel, changes of address and if they are residing in households with children.[39] Practitioners talking to each other, including in their meetings under MAPPA Level 1 or through other safeguarding arrangements, can help build a picture of potential safeguarding risk.

**Non-engagement signals risk.** 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.

**Understanding the impact of incarceration.** Long custodial sentences, especially those served in adult prisons during adolescence, can affect an individual's ability to engage with practitioners. Practitioners should consider the psychological and relational impact of incarceration when assessing parenting capacity and risk.

**Specialist expertise is essential.** Children's services practitioners often lack training and expertise in understanding the risks and behaviours associated with offending. Access to criminal justice expertise, including probation and specialist police teams, is vital for informed risk assessment and planning. Safeguarding partners should consider the inclusion of appropriately experienced criminal justice practitioners within multi-agency child protection teams.

**Information sharing needs to be proactive and purposeful.** Effective safeguarding depends on timely and accurate information sharing. Practitioners should not rely solely on offenders to disclose relevant details. Instead, systems should be strengthened to ensure that information about an offender's relationships, children and risk factors is routinely shared across agencies.

39 UK Parliament, 'Sexual Offences Act 2003', available at: www.legislation.gov.uk/ukpga/2003/42/contents

**MAPPA should prioritise child safeguarding.** Child protection should be seen as core business for MAPPA, including at Level 1. Practitioners require clear guidance, local audit processes and dedicated space for inter-agency reflection focused on children's safety.

**The voluntary sector can play a key role.** Voluntary organisations can offer restorative, relationship-based support that complements statutory services. Practitioners should consider how these services can be integrated into safeguarding plans, especially when engagement with statutory agencies is limited.

# Serious offenders and child protection

4.1 The safety of children is always a concern when serious violent or sexual offenders are involved in parenting. 'Sex Offender Recidivism: Some Lessons Learned from Over 70 Years of Research' considers that there is always some risk of sexual re-offending:

"The risk cannot be null given that offenders have committed at least one sexual offence in the past and past behaviours are the best predictor of future behaviours."[40]

4.2 Child protection can be more effectively managed when: a) risks are known and understood, b) the individual engages with professionals, and c) appropriate support is available. However, when risks are unclear, engagement is lacking or support is unavailable, safeguarding becomes significantly more difficult.

4.3 Support from criminal justice professionals, such as probation, is vital. They should be embedded within local safeguarding networks, with strong collaboration across children's services, health, education and offender specialists. This is especially important when a parent is a serious offender and engagement is limited. Access to criminal justice expertise should be included in local area planning for multi-agency child protection teams.

40 P. Lussier, S. Chouinard Thivierge, J. Fréchette and J. Proulx, 'Sex Offender Recidivism: Some Lessons Learned from Over 70 Years of Research', Criminal Justice Review, (2023), available at: https://journals.sagepub.com/doi/full/10.1177/07340168231157385

# Managing child protection risks at MAPPA Level 1

4.4 Multi-agency public protection arrangements (MAPPA) co-ordinate the management of serious and violent offenders across 42 criminal justice areas in England and Wales. Led by police, probation and prison services, MAPPA involves other agencies such as children's social care, housing, education and health, who have a duty to co-operate.

4.5 MAPPA is a framework for information sharing and co-ordination, not a decision-making body. Agencies retain full statutory responsibilities and operate within their own legal frameworks.

4.6 MAPPA operates at three levels:

Level 1: Lead agency with informal support; no formal meetings unless risks escalate. Over 98% of offenders are managed at this level.

Level 2: Formal multi-agency meetings improve risk management.

Level 3: Reserved for the most complex or high-profile cases.

4.7 Formal meetings are mandatory at Levels 2 and 3 but can be convened at any level. In March 2024, 93,436 individuals were managed under MAPPA, 44% more than in 2014, and MAPPA resource pressures continue to grow. Further information on MAPPA levels and management can be found in the statutory guidance 'Multi-agency public protection arrangements'.[41]

4.8 Under the Sexual Offences Act 2003, registered sex offenders must notify police of travel, changes of address and if they are residing in households with children.[42] There is no requirement to provide details of new partners or pregnancies and there is no system for routinely checking the accuracy of the information provided. Therefore, case officers often do not have a full picture of the safeguarding risks unless the information has been voluntarily shared.

41 MAPPA, 'MAPPA Guidance', (2024), available at: https://mappa.justice.gov.uk/MAPPA/view?objectID=5682416

42 UK Parliament, 'Sexual Offences Act 2003', available at: www.legislation.gov.uk/ukpga/2003/42/contents

4.9 Management of sexual offender or violent offender (MOSOVO) teams are not therapeutic services. Officers receive basic training in offender pathways, but they lack expertise in trauma or sexual offending psychology. Access to specialist interventions typically depends on MAPPA escalation or third-sector involvement. Despite these limitations, MOSOVO officers play a vital role in safeguarding by monitoring compliance, sharing information and linking criminal justice with health and social care.

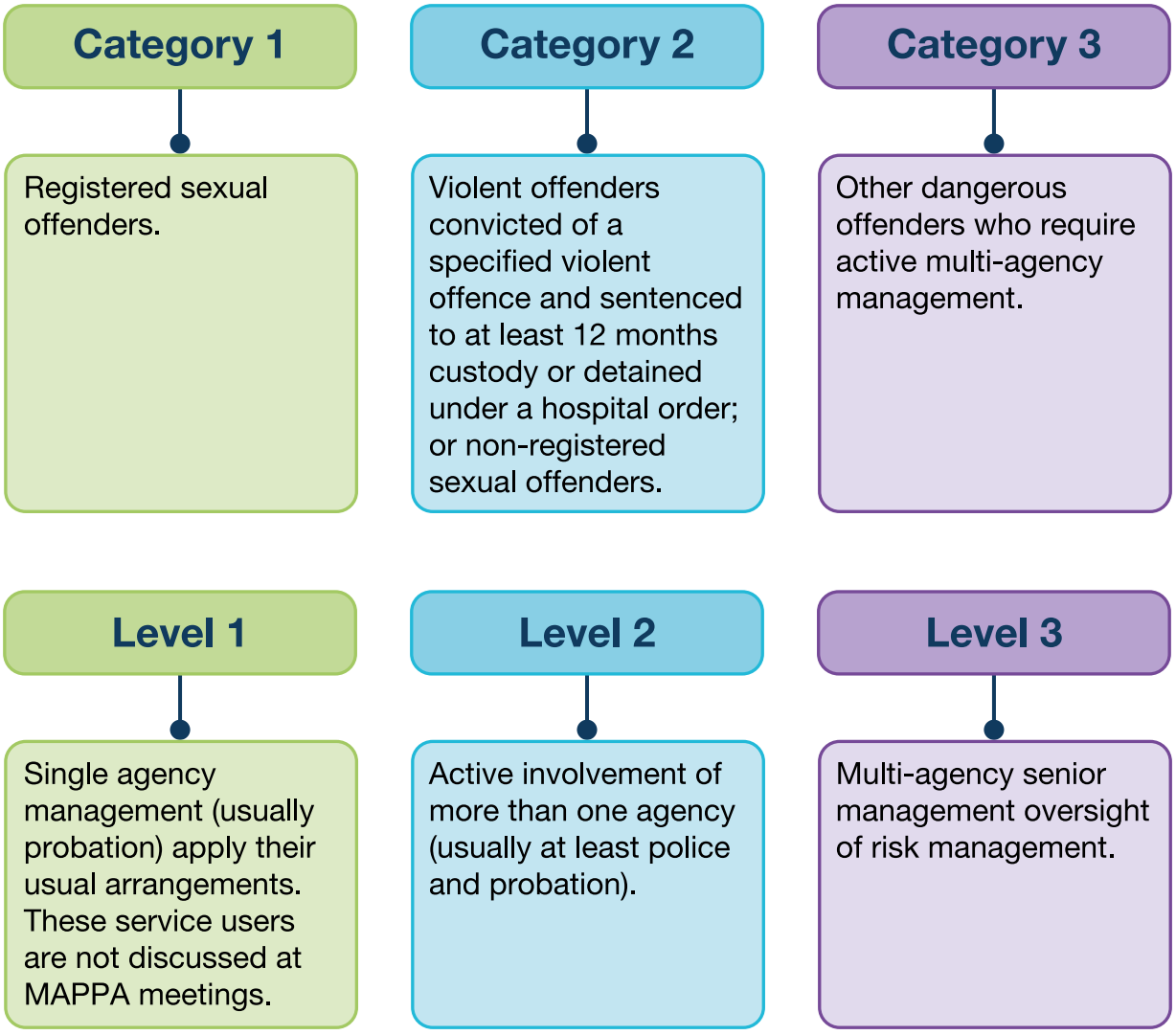
4.10 Voluntary organisations such as Circles UK and the Lucy Faithfull Foundation offer restorative support to offenders, helping reduce risk. However, resource constraints, particularly in probation and police services, limit availability.

4.11 The 2022 MAPPA inspection found Level 2 thresholds too high, excluding complex cases from multi-agency oversight, even when child protection concerns are present. As noted:

> "In some areas, [the threshold for MAPPA Level 2 support] has become too high and too narrow in scope… meaning that 'complex cases' are rejected when multi-agency oversight and accountability are much needed."[43]

43 HM Inspectorate of Probation, 'A joint thematic inspection of Multi-Agency Public Protection Arrangements', (2024), available at: hmiprobation.justiceinspectorates.gov.uk/document/a-joint-thematic-inspection-of-multi-agency-public-protection-arrangements/

**Figure 4: Multi-agency public protection arrangement levels**



# Critical moments and systemic gaps

4.12 There were two key moments when risks posed by Mark Gordon required a stronger inter-agency response:

2017: Mark Gordon was arrested for assaulting two female police officers at the birth of his first child with Constance Marten. Care proceedings began, but more effective MAPPA arrangements should have seen this information shared between agencies to assist the assessment of risk of, for example, domestic abuse, coercive control and non-engagement. Probation and police should have been involved in safeguarding meetings.

2019: Constance Marten sustained life-threatening injuries during pregnancy, later found by the family court to have been caused by Mark Gordon. Despite this, there was no review of his risk assessment or escalation of oversight, even as non-engagement became entrenched.

4.13 These missed opportunities highlight the need for MAPPA to treat child safeguarding as core business. When serious offenders do not engage, risk is harder to assess and must be interpreted collaboratively. Practitioners need access to criminal justice expertise and clearer guidance to understand what 'not knowing' means in the context of risk.

4.14 Since 2017, statutory guidance Working Together to Safeguard Children has strengthened expectations for multi-agency collaboration. To close the gap between offender management and child protection, probation and police should 'think child', and children's services should consider which agencies are involved with any adults who are around at-risk children. Formal arrangements should avoid duplication and use the most effective safeguarding levers, including co-ordination through the forthcoming multi-agency child protection teams.

4.15 The review heard concerns about gatekeeping access to MAPPA panel support. One Jigsaw case manager reflected:

"I don't think MAPPA would have made much difference. You need a specific ask to go to MAPPA. There isn't space in the system for prevention and hypotheticals. It's needed but where does it go?"

4.16 Non-escalation to MAPPA Level 2 often occurred as children's social care were already involved and multi-agency working was perceived as sufficient. In Mark Gordon's case, while information sharing between Jigsaw and children's services was effective, Jigsaw caseworkers lacked safeguarding expertise resulting in limited joint analysis of risk.

4.17 A recent LCSPR received by the Panel revealed similar gaps: a MAPPA Level 1 offender concealed a long-term relationship and two children for over five years.[44] Despite being assessed as medium risk, he was later convicted of over 30 sexual offences. This highlights the challenges of Level 1 management, but whether offenders are managed at Level 1 or Level 2, without voluntary disclosure there is a continued need to effectively share, scrutinise and be professionally curious regarding changing circumstances and risk levels. Without formal multi-agency discussions and proactive information sharing, services such as GPs and schools may remain unaware of serious risks.

4.18 Practitioners working with children of serious offenders need access to specialist expertise. The Panel's national review into child sexual abuse within the family environment stressed the importance of close collaboration between criminal justice and children's services. It recommended robust assessment and management of individuals who pose a sexual harm risk and have contact with children (Recommendation 4, 'I wanted them all to notice' Child Safeguarding Practice Review Panel, 2024). Regular multi-agency discussions are essential to keep risk assessments current and co-ordinated.

4.19 The majority of offenders, including most RSOs, are managed by a single agency at MAPPA Level 1. The 2022 MAPPA inspection recommended:

Recommendation 8: Accept multi-agency oversight of complex cases as a valid reason for Level 2 or 3 adoption.

Recommendation 10: Conduct twice-yearly audits of MAPPA cases, including Level 1 and rejected referrals, to drive good practice and develop MAPPA Chair skills.

Changes have been made to the MAPPA guidance to reflect these recommendations. The MAPPA guidance now states that cases should be considered for Level 2 management where:

- formal multi-agency meetings would add value to the lead agency's management of the risk of serious harm posed

and one, or more, of the following applies:

- the offender is assessed as posing a high or very high risk of serious harm
- exceptionally, the risk level is lower, but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm

44 City & Hackney Safeguarding Children Partnership, 'Case Reviews', (2025), available at: www.chscp.org.uk/case-reviews/

- the case requires oversight at a more senior level
- the case has been previously managed at Level 3 but no longer requires Level 3 management[45]

4.20 Nationally, Ministry of Justice and HM Prison and Probation Service (HMPPS) have worked to improve co-ordination between safeguarding and criminal justice systems. Guidance now clarifies that case complexity can justify referring an offender to MAPPA, helping to strengthen links with MARAC where safeguarding concerns exist. However, further work is needed to ensure that children's safeguarding systems are effectively aligned with criminal justice processes. It is essential that safeguarding partners work closely with probation to clarify roles, share expertise and support practitioners working with families where a parent is a serious offender.

4.21 Serious offenders who are also parents can fall through the gaps between criminal justice and child protection systems. When offender management does not fully consider parenting roles or risks to children, safeguarding responses may be delayed or insufficient. To address this, MAPPA should treat child protection as core business, even at Level 1, and ensure that complexity and non-engagement trigger multi-agency oversight, audit and reflection. Practitioners need access to specialist expertise, clearer guidance and stronger inter-agency accountability to manage risk effectively and protect children of serious offenders from harm.

## Shifting thinking and practice: understanding the risks offenders pose to children

4.22 Mark Gordon's background and experience illustrate the complex factors influencing risk to children beyond the offence itself. Practitioners need to consider an offender's experience of custody, engagement with rehabilitation, mental health and substance use, and the impact of racism and discrimination. Long-term incarceration, especially from a young age, can shape how offenders relate to authority and seek help, affecting parenting and co-operation with professionals long after release. The current system is heavily assessment-driven, yet constrained by capacity. Offenders who do not engage may therefore exclude themselves from available support and many perceive state involvement as punitive, further limiting co-operation.

45 HM Inspectorate of Probation, 'A joint thematic inspection of Multi-Agency Public Protection Arrangements', (2024), available at: hmiprobation.justiceinspectorates.gov.uk/document/a-joint-thematic-inspection-of-multi-agency-public-protection-arrangements/

# 5. Domestic abuse

This chapter explores the complex and persistent impact of domestic abuse, coercion and control on children, with a particular focus on how these dynamics affect parental capacity and professional responses. Drawing on national data, legislative reforms and safeguarding reviews, it highlights the challenges practitioners face when victims do not engage with support, and when abuse is obscured by complex relational dynamics. The chapter calls for trauma-informed, multi-agency approaches that anticipate persistent lack of engagement, recognise patterns of coercion and control, and ensure that both adult and child safeguarding are integrated into practice systems.

Safeguarding agencies held long-standing concerns that domestic abuse, coercion and control were present in the relationship between Constance Marten and Mark Gordon. Early referrals for multi-agency support were limited and ultimately ineffective due to the couple's persistent denial and lack of engagement. Agencies struggled to assess Mark Gordon as a perpetrator following his arrest in 2017, and, when the family relocated, critical safeguarding concerns were lost in the transfer process and the ending of the supervision order.

In 2019, following a serious incident in which Mark Gordon caused Constance Marten to fall from a window, police referred the family to children's social care. Officers noted inconsistencies in the couple's account, raising suspicions of domestic abuse. Social care recognised the risk posed to the children and took immediate safeguarding action, resulting in their removal from the home. While the police followed up on their safeguarding concerns, they could have demonstrated more professional curiosity in response to the incident, proactively treating it as domestic abuse.

Further gaps in possible safeguarding responses became evident. No specialist domestic abuse referrals were made for Constance Marten in either LB2 or LB3, and no MARAC referrals were initiated despite a family court finding of fact which confirmed that Mark Gordon had caused Constance Marten's fall while she was pregnant, resulting in serious injury. There were no joint referrals or expert consultations to help professionals understand the complex dynamics of the couple's relationship or to support Constance Marten in recognising the harm she had experienced. Practitioners were confounded by the couple's insular and co-dependent relationship, which defied conventional narratives of victim and perpetrator.

Constance Marten's confident presentation, denial of abuse and reluctance to engage with services, all masked her own vulnerability. These systemic gaps in understanding both individuals in all their complexity, what was happening in their relationship and how best to respond to it and to them both, ultimately left the children exposed to harm and isolated from external support, necessitating their removal as the only viable protective measure.

The review asked Constance Marten:

> "How did contact with child safeguarding agencies make you feel?"

Constance Marten said:

> "I was given ultimatums, rather than true assistance. It felt like they were using the powers of the state coercively rather than constructively. It felt, in a way, that there was a flow chart which would ultimately result in the removal of my children, step by step. My mistrust of social services is not an innate feature of my personality, it developed due to my dealings with them."

## Key learning for practitioners: domestic abuse

**Domestic abuse should be recognised as a core safeguarding concern.** It is a significant risk factor in cases of serious harm or child death, particularly where patterns of coercion and control are present. Practitioners need to treat domestic abuse as central to child protection, not peripheral.

**Non-engagement may be a trauma response.** Victims of domestic abuse may not engage with services due to fear, trauma, or complex relational dynamics. This should not be interpreted as lack of consent or absence of risk. Systems should anticipate and respond to persistent lack of engagement with empathy and persistence.

**Coercive control can obscure vulnerability.** Victims may present as confident or deny abuse, masking their vulnerability. Professionals should look beyond surface behaviours and consider the broader context of trauma, isolation and control.

**Multi-agency co-ordination is essential.** Effective safeguarding requires collaboration across children's services, police, health and domestic abuse specialists. MARACs and MAPPA need to be used proactively, especially when serious harm has occurred or been legally established.

**Specialist expertise is needed to interpret complex dynamics.** Relationships involving mutual harm, denial or minimisation require nuanced understanding. Practitioners should seek expert consultation to assess risk and formulate appropriate responses.

**Support needs to be accessible and sustained.** Offers of help should be tailored to the victim's capacity to engage. Services should be trauma-informed, culturally sensitive and persistent, recognising that achieving safety and change takes time.

**Case transfers should retain critical information.** Domestic abuse concerns need to be clearly documented and transferred between agencies to avoid loss of insight and risk escalation.

# Embedding legislative and guidance changes

5.1 Domestic abuse remains one of the most significant risks of serious harm to children and young people. The Panel's Annual Report 2023 to 2024 found that in 47% of cases where a child died or was seriously harmed, rapid reviews identified domestic abuse within the household – particularly affecting babies under 12 months.[46] The Domestic Abuse Commissioner's 'Victims in their own right? Babies, children and young people's experiences of domestic abuse' report estimates that 30% of domestic abuse begins during pregnancy, though underreporting suggests the true figure may be higher.[47]

5.2 In the year to 30 June 2025, over 129,000 high-risk adult cases were discussed at around 280 MARACs, involving 155,000 children.[48] The Domestic Abuse Act 2021 and the Home Office's 'Tackling Domestic Abuse Plan' introduced reforms to police practice, recording systems and multi-agency co-ordination.[49] The Domestic Abuse 2021 Act now recognises children as victims in their own right if they see, hear or experience domestic abuse, a change that has since been reflected in Working Together to Safeguard Children.

46 HM Government, 'Child Safeguarding Practice Review Panel: annual report 2023 to 2024', (2024), available at: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2023-to-2024

47 Domestic Abuse Commissioner, 'Victims in their own right? Babies, children and young people's experiences of domestic abuse', (2025), available at: www.gov.uk/government/publications/babies-children-and-young-peoples-experiences-of-domestic-abuse

48 SafeLives, 'Our quarterly Marac data', (2025), available at: https://safelives.org.uk/research-policy/practitioner-datasets/marac-data/

49 UK Parliament, 'Domestic Abuse Act 2021', (2021), available at: www.legislation.gov.uk/ukpga/2021/17/contents; HM Government, 'Tackling Domestic Abuse Plan', (2022), available at: www.gov.uk/government/publications/tackling-domestic-abuse-plan

5.3 MAPPA guidance has also evolved, encouraging the use of Category 3 ('other dangerous offenders') in domestic abuse cases.[50] This is particularly relevant in cases like Mark Gordon's, where serious harm occurred but oversight was limited. The Panel's briefing paper 'Multi-agency safeguarding and domestic abuse' identified four core principles – domestic abuse informed, whole family, trauma-informed, and intersectional – as essential for effective multi-agency safeguarding.[51]

5.4 These principles align with learning from this review where police and children's social care acknowledged missed opportunities to recognise Constance Marten's vulnerability and have since invested in specialist domestic abuse services. While reforms are beginning to show impact, cultural and behavioural change takes time, especially around coercive control, which remains poorly understood. Rapid reviews and LCSPRs that are considered by the Panel continue to reinforce the importance of these four core principles, and a sustained, all-agency leadership focus is needed to embed evidence-led practice and improve communication between adult and children's services.[52]

## Shifting thinking and practice: domestic abuse and non-engagement

5.5 The review highlights a strong connection between domestic abuse and non-engagement with services. Rapid reviews and LCSPRs considered by the Panel consistently show that many women, despite experiencing multiple incidents of abuse, MARAC referrals and repeat child protection plans, struggle to accept support or recognise the harm affecting them and their children. In some families, over 20 incidents were recorded before meaningful intervention occurred. This underlines the need for persistent, trauma-informed engagement strategies.

50 Category 3: other dangerous offenders – who have been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm, and which requires multi-agency management. MAPPA, 'Multi-Agency Public Protection Arrangements', available at: https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome

51 HM Government, 'Multi-agency safeguarding and domestic abuse: paper', (2024), available at: www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper

52 HM Government, 'Safeguarding children under 1 year old from non-accidental injury', (2022), available at: www.gov.uk/government/publications/safeguarding-children-under-1-year-old-from-non-accidental-injury; HM Government, 'Child Safeguarding Practice Review Panel: annual report 2023 to 2024', (2024), available at: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2023-to-2024

5.6 Practitioners often found themselves managing known risk without a clear strategy, particularly when the vulnerable parent could not engage. This led to a binary choice: either mitigate risk through safety planning or remove children from parental care, sometimes involving mothers who had previously lost children to care. There is the opportunity to use existing meeting structures to establish a multi-agency risk strategy and plan through strategy discussions or as part of section 47 enquiry.

5.7 People often stay in harmful relationships for complex, personal reasons, such as past trauma or life challenges. What feels safe to them may seem irrational to practitioners and, in cases of mutual harm or denial, assessing risk becomes even harder.

5.8 Safeguarding systems often expect vulnerable women to navigate complex processes, assessments, referrals and signposting despite limited internal capacity to respond. This mismatch can cause further harm, especially when compounded by discrimination, racism and exclusion. The Panel's report 'Race, Racism and Safeguarding Children' stresses the need for leaders to create safe conditions for practitioners to explore these issues and reflect on bias.[53]

5.9 When working with Constance Marten and Mark Gordon, professionals struggled to interpret the dynamics of a deeply enmeshed, co-dependent relationship. Despite repeated denials of abuse, a 2021 Family Court finding confirmed that Mark Gordon had caused Constance Marten to fall from a window while pregnant, yet no MARAC referral or MAPPA review was undertaken. Their children lived within an isolated bubble, and the lack of engagement significantly reduced the potential for professional insight or supported change. Ultimately, removal of their children became the only safe option.

5.10 Supporting victims of domestic abuse, especially where coercive control is present, requires practitioners to anticipate that some individuals may be unable or unwilling to engage with support. This calls for co-ordinated, multi-agency risk assessment and response. MARACs play a vital role in identifying risk, including cases where children previously unknown to services are exposed to domestic abuse. While MARACs and linked Independent Domestic Violence Advisors can be effective, their impact depends on consent and engagement, which is often absent in high-risk cases.[54] Although MARACs can proceed without consent, this rarely improves engagement.

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53 Child Safeguarding Practice Review Panel, 'Race, racism and safeguarding children', (2025), available at: www.gov.uk/government/publications/race-racism-and-safeguarding-children

54 E. Howarth, L. Stimpson, D. Barran and A.L. Robinson, 'Safety in numbers: a multisite evaluation of independent domestic violence advisor services', (2009), available at: https://orca.cardiff.ac.uk/id/eprint/24235/

5.11 Professionals need dedicated spaces, within MARAC or elsewhere, to discuss domestic abuse concerns, especially where children may be vulnerable but harm is not acknowledged within the family. Specialist expertise is essential to help practitioners understand complex relational dynamics, identify hidden vulnerabilities and assess how power imbalances shape risk to children.

5.12 The work of Brid Featherstone, Kate Morris and colleagues, including a major ongoing research project funded by Nuffield Foundation, evidences the need for a more nuanced, holistic approach to social work and child protection where domestic abuse and coercive control is known or suspected. This aligns with findings from the Domestic Abuse Commissioner's 'Victims in their own right? Babies, children and young people's experiences of domestic abuse' report which stresses the importance of differentiating between types of abuse and levels of risk. Practitioners need to recognise both the direct harm to children and the ways in which abusive relationships may stem from unresolved trauma.

5.13 Domestic abuse should be central to child protection planning. Practitioners need tools, training and reflective space to move beyond surface-level assessments and engage meaningfully with families, especially when engagement is limited or obscured by trauma. The absence of co-ordinated support following care proceedings left Constance Marten and Mark Gordon isolated and unsupported, increasing the risk to their children. A shift in practice is needed: one that anticipates vulnerability, builds trust, and integrates adult and child safeguarding responses to prevent harm and promote long-term change.

# 6. Families who move

This chapter builds on the systemic learning already identified within this national review, extending the analysis with a focus on the safeguarding implications when families known to statutory agencies move frequently across geographical boundaries. The frequent relocations undertaken by Constance Marten and Mark Gordon illustrate how such action, often aligned with increasing risk, can disrupt oversight, hinder multi-agency co-ordination and obscure critical safeguarding information. These challenges are not unique to Victoria's short life; they are reflected in numerous LCSPRs and national data.

The review also explores how safeguarding systems respond to challenges in anticipating 'flight' behaviours and how they should continue to develop systems to ensure that timely and formalised transfers of responsibility maintain clear accountability between local authorities. It highlights the importance of robust mechanisms such as CP-IS, the NHS Safeguarding Missing Person Protocol for health (publication pending) and consistent use of shared care records to protect vulnerable infants when families move and do not register with services or make their whereabouts known. The learning presented here complements earlier chapters by reinforcing the need for proactive, trauma-informed and co-ordinated multi-agency safeguarding responses.

Constance Marten and Mark Gordon moved five times during their five pregnancies between 2017 and 2023, with each move coinciding with escalating safeguarding concerns. Their first move in 2017 involved presenting under false identities at a maternity service in W1, triggering a national alert and initiating care proceedings.

In 2018, they returned to LB2 while under a supervision order. Constance Marten was pregnant, though this was not known to practitioners. The transfer of responsibility between the two local authorities was not optimal, with no joint decision-making or co-ordinated inter-agency handover involving police, health and children's social care. The practitioners in W1 were concerned about the impact of the move, but these concerns were not shared with LB2. This lack of clarity and shared understanding undermined safeguarding efforts and contributed to missed opportunities for intervention.

In 2019, Constance Marten fled to Ireland with her two children to avoid a section 47 investigation. This third move further disrupted oversight and highlighted the need for anticipatory safeguarding responses. By 2021, three children were in care, and the couple had moved to LB3. Although communication between LB2 and LB3 improved during the fourth pregnancy, more in-depth discussion to agree a shared approach might have focused professional attention more keenly on the potential for a further pregnancy. This could have allowed scope for identifying and agreeing longer-term work with Constance Marten and Mark Gordon, as well as making sure that necessary pre-birth safeguarding decisions were made.

Their final move in 2022, while pregnant with Victoria, resulted in total disengagement from services. The couple had no support and minimal contact with agencies. Contact was only maintained due to Mark Gordon's reporting requirements as a registered sex offender. The circumstances surrounding their 'flight' triggered a national police search and underscored the challenge of locating vulnerable pregnant women and unborn infants. It also highlighted the urgent need for clear multi-agency mechanisms to agree and determine legal responsibility when residency is unclear. This is essential to ensure that action is taken quickly to safeguard and support children and their families.

Victoria's short life and death reinforces the importance of robust, anticipatory safeguarding systems and formalised transfer processes to protect vulnerable children and unborn infants when families move.

Moving home can be a necessary and beneficial part of family life. However, multiple moves may signal that a family is struggling or seeking to evade statutory oversight. At its most extreme, as seen with Victoria, relocation can be an attempt to disappear entirely from professional view.

## Key learning for practitioners: families who move

**Frequent moves can signal risk.** Repeated relocations, especially during pregnancy or while subject to child protection processes or court orders, may indicate attempts to evade agency oversight. Moves should be treated as a potential safeguarding concern, not just a logistical change.

**Transfers should be formal, multi-agency and well-documented.** Poorly managed transfers between local authorities can result in the loss of critical safeguarding information, professional insight and continuity of care. Inter-area meetings should be convened promptly, with clear decisions about accountability and case ownership.

**Supervision orders require joint oversight when families move.** Legal responsibility may remain with the originating authority, but both areas need to collaborate to ensure effective monitoring and risk management. Failure to do so can result in missed opportunities to intervene.

**Safeguarding systems should anticipate 'flight' behaviour.** Where families have a history of moving and safeguarding concerns exist, agencies should proactively plan for future moves. This includes having up-to-date chronologies, assessment summaries and agreed contingency plans in readiness for the next move.

**National alert systems need clarity and consistency.** The informal continuation of discontinued systems (or example, national maternity alerts) created confusion and false assurance. Health agencies need to follow the NHS Safeguarding Missing Person Protocol for health (publication pending) and ensure pre-birth child protection plans are recorded in Child Protection Information System (CP-IS) and shared care records.

**Unborn infants are especially vulnerable.** When pregnancy is suspected but unconfirmed, and families are mobile, safeguarding responsibility can become ambiguous. Clear protocols are needed to determine which area holds accountability for oversight and how concerns are escalated.

**Information should be accessible and transferable.** 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.

# Safeguarding alert systems

6.1 Constance Marten's first pregnancy in 2017 highlighted the need for rapid communication between statutory agencies when safeguarding concerns arise for vulnerable women and unborn infants. As concerns for their unborn infant escalated in LB1, the couple moved to a tent on waste ground in W1 and presented at a maternity service under false identities.

6.2 At that time, a formal system called 'national maternity alerts' was used to share concerns about pregnant women who disengaged from services. This system was discontinued for valid reasons following maternity service reforms in 2017, shortly after being used to confirm Constance Marten and Mark Gordon's identities. Despite its abolition, many maternity units continued to use the alert system informally, creating confusion. Information was shared via local email lists, giving the impression that a national process remained in place. Children's social care colleagues who contributed to the review reported they were unaware that the alert system was informal.

6.3 NHS Safeguarding responded to the issue of prevailing local informal alert systems in 2020 by producing national guidance for health services. The guidance is well understood across health providers and has been formalised into the NHS Safeguarding Missing Person Protocol (publication pending). Safeguarding partners should ensure health agencies are using the NHS Safeguarding Missing Person Protocol, that other safeguarding partners are aware of the protocol and that NHS Trusts confirm that informal alert practices have ceased.

6.4 The CP-IS service is central to identifying that a baby or child, including those unborn, is vulnerable and has a child protection plan. Established to record and communicate to unscheduled care settings information about children who are on child protection plans or those who are 'looked after', its function includes unborn infants on a pre-birth child protection plan. If safeguarding concerns arise and a pre-birth plan is not already in place, standard referral and child protection assessment procedures should be followed.

6.5 The review heard how CP-IS can be checked when a pregnant woman presents unexpectedly in an unscheduled care setting, such as an emergency department. CP-IS should also be checked when a woman attends in labour or for an antenatal assessment without prior antenatal care in that maternity service, or if a woman attends for an antenatal booking appointment at more than 16 weeks gestation, which is classed as a late booking. Typically, women who are already booked into a maternity service and move late in pregnancy hold their own maternity records detailing antenatal care to date; failure to do so may raise concerns that need to be explored further.

6.6 Safeguarding concerns for the unborn infant should also be recorded in the mother's NHS primary care record, held by the GP surgery, using 'SNOMED' codes. These codes on GP systems flag unresolved safeguarding issues. However, the review found their use is inconsistent across GP surgeries.

6.7 The Royal College of General Practitioners has emphasised the importance of coding safeguarding concerns. Their advice recommends that where coding systems are not in use, safeguarding information should be clearly documented in a visible section of the primary care record, including any related family information.[55]

6.8 The review has considered the Children's Wellbeing and Schools Bill which is currently before Parliament, which proposes to implement multi-agency child protection teams and a national single unique identifier (SUI) to consolidate information about a child across health, police, children's social care, justice and education. This would improve agency co-ordination and confidence in shared data. However, the proposed SUI does not currently apply to unborn infants. While promising for future child protection, it does not yet address safeguarding concerns for unborn infants. This is an area the Department for Education should cover in the accompanying statutory guidance.

## Shifting thinking and practice: system learning

6.9 A more formalised approach is needed for transferring information and determining local authority accountability when families known to safeguarding agencies move. Decisions about which authority holds responsibility needs to be clear and transparent.

6.10 The statutory duty to safeguard and promote a child's welfare lies with children's social care, based on the child's usual residence. When residency is unclear, such as during geographical transience, accountability becomes ambiguous.

6.11 Data from the Panel's Annual Report 2022 to 2023 shows that safeguarding partners frequently face challenges when families known to agencies move across geographical boundaries. These families often have multiple vulnerabilities such as being young parents, unstable housing and lacking support networks. This complexity can increase the risk of losing critical safeguarding information during transfers. The challenges intensify when children are subject to supervision orders, as seen with Sibling 1.

55 Royal College of General Practitioners, 'RCGP Safeguarding toolkit: Introduction', (2025), available at: https://elearning.rcgp.org.uk/mod/book/view.php?id=15290

6.12 Moves involving families with child protection concerns require the transfer of comprehensive records including court documents, social care files, health and education plans, and police involvement, alongside multi-agency insights into risks, needs and strengths. The Panel's Annual Report 2022 to 2023 suggested that:

"Where children move from one area to another, systems need to ensure that practitioners request and access previous records, including from children's social care, so that there are no gaps in safeguarding practice when families move."[56]

This diagram shows how children's social care, health, police, and housing work together under the 'Think Family' approach. It promotes shared responsibility, timely information exchange and holistic support to reduce risk when families move.

**Figure 5: Think Family model for multi-agency collaboration**

**Adopting a 'Think Family' approach is crucial because it considers the needs of the whole family, enabling more effective interventions, crisis prevention and long-term wellbeing**

| | | |
|---|---|---|
| **Holistic assessment:** Assessing the needs of the whole family, not only the child receiving direct support. | **Integrated services:** Co-ordinating support across services to ensure a seamless, collaborative multi-agency response. | **Early intervention:** Identifying and addressing issues early to prevent escalation and reduce the need for intensive intervention. |
| **Shared responsibility:** Recognising safeguarding as everyone's responsibility, underpinned by effective communication and collaboration. | **Strengths-based approach:** Focusing on family strengths and resources to overcome challenges. | **Cultural sensitivity:** Being aware of and respecting the cultural backgrounds and values of the families being supported. |

56 Child Safeguarding Practice Review Panel, 'Child Safeguarding Practice Review Panel: Annual Report 2022 to 2023', (2024), available at: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2022-to-2023

6.13 Delays and incomplete case histories can obscure the nuances of children's needs and professional judgement. Brief summaries often fail to convey the complexity of risk and the nature of previous interventions.

6.14 When Sibling 1 moved from W1, poor information transfer and a lack of professional discussion led to missed safeguarding opportunities, including:

- loss of the concerns held about coercion and control within the couple
- loss of recognition of the long-term risks, including entrenched non-engagement of the couple and lack of insight into the particular risks posed by Mark Gordon
- missed identification of a concealed pregnancy
- consideration of whether the move was intended to evade professional oversight
- no joint review of the care plan linked to the supervision order
- timely contextualisation of the new referrals received by LB2

6.15 A known history of multiple moves or escalating non-engagement should trigger a proactive safeguarding response. Agencies should agree on actions to mitigate risk if a family moves again. Moving should be recognised as a potential risk factor. Patterns of relocation may reflect a trauma-related 'flight' response rather than deliberate evasion. Agencies should explore underlying causes and develop shared plans to build trust, reduce concerns and clarify actions if risks persist.

6.16 Information needs to be accessible and transferable. Agencies should maintain up-to-date chronologies, assessment summaries and records of multi-agency work to support swift responses in the event of a move. Anticipating moves enables timely inter-area transfer meetings and co-ordinated safeguarding action.

6.17 Transfers of responsibility should be formally managed through documented multi-agency discussions that:

- involve both areas to agree on timing and approach
- include all relevant agencies to ensure a full understanding of risks and needs
- preserve professional judgement and nuanced insight into the family's situation

# Residence and case transfer: clarifying responsibility and oversight

6.18 Local authorities hold the statutory duty to safeguard children based on where the child 'usually resides'. When a family moves, responsibility typically transfers to the new area unless the move is temporary.

6.19 If a family's intentions around residency are unclear, or if they have moved repeatedly in a short period, decisions about case transfer should be carefully considered. This includes reviewing any incomplete assessments and ensuring continuity of oversight.

6.20 Supervision orders present particular challenges. Legal responsibility remains with the originating authority, even if the family relocates. In such cases, the involved areas may:

- share information and agree on joint oversight arrangements
- apply to the Family Court to redesignate or extend the order based on the new residence

6.21 Transfers need to be timely, transparent and well-documented to avoid ambiguity about the level and nature of risk. Decision-making should reflect the complexity of the case and be informed by professional judgement.

6.22 Concealed pregnancies combined with frequent moves, can leave unborn infants highly vulnerable. Clear protocols are needed to determine which area holds responsibility for safeguarding oversight and to ensure that information is shared in a timely manner.

6.23 A mechanism is needed to resolve disputes about which area should assume responsibility. While adult services rely on the Department of Health and Social Care for arbitration, this review concludes that a local approach is preferable for children's services. Future iterations of statutory guidance Working Together to Safeguard Children should outline clear principles to support local arbitration and decision-making.

# 7. Recommendations

## Protecting babies and unborn infants

### National recommendation

1. 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 infants when there are child protection risks.

### Recommendations to safeguarding partners in England

2. Safeguarding partners should have a multi-agency pre-birth protocol for unborn infants that includes concealed pregnancy, with a focus on vulnerable babies, when there are child protection risks.
3. Safeguarding partners should review the quality, robustness and consistent implementation of pre-birth protocols to ensure practice and delivery is in line with 'Born into Care: Best practice guidelines for when the state intervenes at birth'.[57]

## Engaging parents

### National recommendations

4. The next version of Working Together to Safeguard Children should make clear that safeguarding partners need to work with all relevant adult services to develop, implement and resource effective parental engagement strategies. This should include developing, implementing and resourcing effective multi-agency parental support planning when parents are no longer able to care for their children. The aim is to reduce the risk of further children being removed from parental care and to promote consistency in local area approaches. The government should keep under review whether these requirements need to be further strengthened in primary legislation.

57 Nuffield Family Justice Observatory, 'Born into Care: Best practice guidelines for when the state intervenes at birth', (2023), available at: www.nuffieldfjo.org.uk/wp-content/uploads/2023/03/nfjo_newborn-babies_best_practice_guidelines_english_20230330-2.pdf

5. The next version of Working Together to Safeguard Children should 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.[58]

## Recommendations to safeguarding partners in England

6. 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)

7. 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.

8. 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.

9. 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.

58 Office for Health Improvement and Disparities, 'Working definition of trauma-informed practice', (2022), available at: www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

# Serious offenders

## National recommendations

10. 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.

11. The 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.

12. Working Together to Safeguard Children should reflect the HMPPS Child Safeguarding Policy Framework, which requires all Heads of Probation Delivery Units to attend local safeguarding partnership meetings where required.

13. Working Together to Safeguard Children should 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.[59]

## Recommendations to safeguarding partners in England

14. 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.

15. 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.

16. 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.

59 For MAPPA guidance, visit: www.mappa.justice.gov.uk/MAPPA/view?objectID=5682416

# Families who move

## National recommendations

17. The next version of Working Together to Safeguard Children should:

    a. 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 (this should include a full case summary and chronology for the transfer-in conference relating to that child and family that adheres to the timescales set out in Working Together to Safeguard Children for child protection and children in need)

    b. 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

## Recommendations to safeguarding partners in England

18. Safeguarding partners should ensure that where practitioners are concerned for the welfare of a missing vulnerable woman and her unborn infant, 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.

19. 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.

# Action for inspectorates

20. Ofsted, the Care Quality Commission, HM Inspectorate of Constabulary and Fire and Rescue Services, HM Inspectorate of Probation and HM Inspectorate of Prisons for England and Wales should consider and act on the findings of this review and revise inspection frameworks accordingly.

# Annexes

## Annex A: Supplementary methodology detail

This annex provides additional detail to complement the methodology outlined in the main body of the review. It expands on the design, evidence sources and contributors involved in the process, and clarifies decisions made during the review's development.

### Review design and structure

The review followed a four-phase structure. These phases included evidence gathering, thematic analysis, development of findings and formulation of recommendations. This annex focuses on the practical implementation of those phases and the rationale behind key decisions.

### Evidence sources and engagement

- Interviews: 43 interviews were conducted with approximately 53 professionals across children's social care, health, police and other relevant agencies. These interviews were structured around key lines of enquiry and focused on periods of significant professional involvement.
- Workshops: Three practitioner workshops were held with professionals from the safeguarding partnership areas most involved. These sessions supported reflection on emerging findings and helped test the relevance of proposed recommendations.
- Document review: A consolidated chronology was developed using agency records, which informed analysis of multi-agency practice between 2017 and 2023.
- Rapid reviews and LCSPRs: 41 local reviews were analysed to identify recurring themes and systemic challenges relevant to the themes raised in Victoria's case and our broader focus on protecting vulnerable babies better.

## Involvement of family and children

Constance Marten provided written answers to questions posed by the review team after the criminal trials had ended. Mark Gordon did not respond to an offer to speak to the review team. Their children were too young to participate directly, but social workers for Victoria's siblings contributed reflections to ensure their experiences were considered.

Relevant research and practitioner insight were used to bring broader parent perspectives into the analysis of the issues raised in this review.

**Sector engagement included:**

- stakeholder workshops with national bodies, inspectorates, Royal Colleges and voluntary organisations
- structured discussions with professionals from children's and adult services, health, criminal justice and policy

## Analytical framework

The review drew on the systemic framework used in previous national reviews, focusing on:

- practice and practice knowledge
- systems and processes
- leadership and culture
- wider service context

This framework supported a holistic analysis of professional decision-making and inter-agency collaboration.

## Limitations and scope

The review did not aim to assign blame or determine causality. It focused on identifying learning to strengthen safeguarding systems. The scope was limited to practice between 2017 and 2023 and did not include retrospective analysis of earlier events unless directly relevant to safeguarding decisions.

# Annex B: Acronyms

| | |
|---|---|
| **ARMS** | Active Risk Management System |
| **CP-IS** | Child Protection Information Sharing |
| **CPP** | child protection plan |
| **FDAC** | Family Drug and Alcohol Courts |
| **GP** | General Practitioner |
| **HMPPS** | HM Prison and Probation Service |
| **LCSPR** | Local Child Safeguarding Practice Review |
| **MAPPA** | multi-agency public protection arrangements |
| **MARAC** | multi-agency risk assessment conference |
| **MOSOVO** | management of sexual or violent offenders |
| **RCGP** | Royal College of General Practitioners |