Newcastle Safeguarding Children Partnership

Briefing: Victoria Marten

13/02/2026

Executive Summary

The death of Victoria Marten in early 2023 was an extreme and tragic case, for which her parents were later convicted of serious criminal offences. The purpose of the national review is not to revisit criminal proceedings, but to draw out wider learning for safeguarding systems. For safeguarding partnerships, the case raises critical questions about how effectively multi-agency arrangements identify, anticipate and respond to escalating risk for unborn babies and infants who are not visible to services.

Victoria was the fifth child born to her parents, following a sustained history of serious safeguarding concerns across multiple local authority areas. Her four older siblings were appropriately protected through care proceedings, despite persistent challenges including parental non-engagement, incomplete disclosure, domestic abuse, serious offending history and repeated cross-border movement. However, by the time Victoria was conceived, her parents had disengaged entirely from statutory services. Her pregnancy was deliberately concealed, she was born outside medical and safeguarding oversight, and the family lived transiently, preventing any professional assessment or pre-birth planning. This represents an escalation of risk beyond that previously encountered in the family's history.

The national review identifies no single professional failure, but highlights recurring systemic challenges that are highly relevant to NSCP's assurance role. These include responding to persistent non-engagement, safeguarding unborn babies where pregnancy is concealed, integrating adult and child safeguarding in cases involving domestic abuse and serious offending, and maintaining oversight when families move across boundaries. The case underscores the importance of proactive, relational and trauma-informed multi-agency practice that anticipates future risk, including future pregnancies, rather than responding only at points of crisis. For NSCP, the learning reinforces the need for strong partnership leadership, effective scrutiny of pre-birth and non-engagement practice, and assurance that local systems are equipped to identify and protect the most vulnerable babies before they are lost from view.

Engaging Parents

The national review highlights that safeguarding becomes significantly more challenging when parents persistently do not engage with statutory services. In Victoria Marten's case, professionals across multiple agencies and local authority areas experienced long-term non-engagement, avoidance of assessment, incomplete disclosure and, ultimately, total withdrawal from services. This severely limited opportunities to understand parental circumstances, assess risk and intervene to protect an unborn baby.

The review emphasises that non-engagement should not be understood solely as resistance or refusal. It may reflect trauma, fear of further child removal, unresolved grief and mistrust of services following previous care proceedings. While trauma does not remove parental

responsibility, failure to understand and respond to its impact can allow risk to escalate unchecked, particularly where future pregnancies are concealed.

The absence of sustained, coordinated, trauma-informed support for parents following the removal of earlier children is identified as a critical system weakness. Without proactive engagement and ongoing multi-agency support beyond proceedings, opportunities to interrupt cycles of harm and anticipate future risk were missed, contributing to Victoria remaining unseen by services.

Key points for safeguarding partners

- Persistent parental non-engagement significantly limits risk assessment and safeguarding effectiveness, particularly for unborn babies.
- Non-engagement may be rooted in trauma, fear and grief following repeated child removals, and should be actively understood rather than treated as a simple refusal.
- Trauma-informed practice must sit alongside clear accountability for child safety; trauma does not remove parental responsibility.
- Safeguarding systems often lack mechanisms to provide sustained, relational support to parents after care proceedings conclude.
- Failure to engage parents proactively and over time increases the risk of concealed pregnancy and unborn babies remaining invisible to services.
- Effective engagement requires coordinated, multi-agency involvement, including adult services, rather than reliance on children's social care alone.

Protecting Babies and Unborn Infants

The national review highlights that unborn babies and infants are at greatest risk when they remain unseen by services. In Victoria Marten's case, her pregnancy was deliberately concealed following the removal of her older siblings, and her birth took place outside medical and safeguarding oversight. This meant that no pre-birth assessment, multi-agency planning or protective intervention could be undertaken, despite a known history of significant risk.

The review emphasises that concealed pregnancy often occurs in the context of trauma, fear and unresolved grief following previous child removals. While there is no legal duty for a woman to disclose a pregnancy, concealment—particularly where there is a history of serious safeguarding concerns—should be understood as a significant indicator of risk for the unborn baby. Failure to anticipate and plan for future pregnancies following care proceedings can leave infants extremely vulnerable.

A key finding is that safeguarding systems are often reactive rather than anticipatory. Support for parents frequently ends when care proceedings conclude, with limited mechanisms to provide sustained, trauma-informed engagement or to prepare for future pregnancies. The review calls for a shift towards proactive, relational and multi-agency safeguarding that protects unborn babies by anticipating risk well before birth.

Key points for safeguarding partners

- Unborn babies are at highest risk when pregnancy is concealed, and infants remain invisible to services.
- Concealed pregnancy is a serious safeguarding indicator, particularly following previous child removals.

- There is no legal duty to disclose pregnancy, which limits safeguarding intervention unless risk is identified through other means.
- Repeated child removals without sustained post-proceedings support increase the likelihood of future concealment.
- Safeguarding practice must anticipate future pregnancies and plan proactively, not only respond once a baby is born.
- Effective protection of unborn infants requires coordinated, trauma-informed multi-agency working, including adult services, beyond statutory child protection timescales.

Managing child protection risks associated with serious offenders

The national review highlights that safeguarding risks increase significantly when a parent or carer has a history of serious violent or sexual offending, particularly where offender management and child protection systems operate in parallel rather than as an integrated response. In Victoria Marten's case, her father had a long history of serious sexual offending and was subject to registered sex offender requirements, yet this did not consistently translate into effective child-focused risk assessment or safeguarding planning.

The review identifies that serious offenders who are parents can fall between the gaps of criminal justice and child safeguarding arrangements, especially when managed at MAPPA Level 1. While information sharing occurred, there were limited opportunities for structured multi-agency analysis of what non-engagement, incomplete disclosure and changing family circumstances meant for risk to children. In Victoria's family, key moments of escalating concern did not trigger enhanced multi-agency oversight or escalation of offender management arrangements.

A core finding is that non-engagement by serious offenders should itself be treated as a safeguarding risk indicator. The review emphasises the need for child safeguarding to be regarded as core business within offender management systems, and for safeguarding partnerships to ensure that criminal justice expertise is routinely integrated into child protection decision-making, particularly where unborn babies and infants are involved.

Key points for safeguarding partners

- Serious offenders who are parents pose complex and heightened safeguarding risks to children, including unborn babies.
- Child protection and offender management systems must be integrated; parallel working increases the risk of missed or underestimated harm.
- Management at MAPPA Level 1 can limit multi-agency oversight unless cases are actively escalated when complexity or non-engagement is present.
- Persistent non-engagement by serious offenders should be treated as a significant safeguarding risk, not a neutral factor.
- Safeguarding practitioners often lack specialist criminal justice expertise, which is essential to understanding risk associated with serious offending.
- Safeguarding partnerships should assure themselves that MAPPA and MARAC arrangements prioritise child protection and enable escalation when children are at risk.

Domestic Abuse

The national review identifies domestic abuse, including coercive control, as a central and recurring safeguarding risk for babies and young children. In Victoria Marten's case, agencies held longstanding concerns about domestic abuse within the parental relationship. These concerns were reinforced by a serious incident during pregnancy that later resulted in a Family Court finding of fact. Despite this, domestic abuse was not consistently addressed through specialist pathways or multi-agency risk forums, limiting opportunities to understand and respond to the dynamics of harm.

The review highlights how domestic abuse can remain hidden where victims deny harm, present as confident or disengage from services. In Victoria's family, persistent denial, non-engagement and an insular, co-dependent relationship obscured vulnerability and reduced professional insight. The absence of specialist domestic abuse assessment and multi-agency risk management meant that escalating risks to unborn and very young children were not fully explored beyond child removal.

A key message for safeguarding systems is that domestic abuse must be treated as core business in child protection, not as a secondary concern. Effective responses require integrated adult and child safeguarding, proactive use of MARAC and MAPPA where appropriate, and trauma-informed practice that anticipates non-engagement while maintaining a clear focus on the safety and welfare of children, particularly babies and unborn infants.

Key points for safeguarding partners

- Domestic abuse is a significant risk factor in cases of serious harm or child death, particularly for babies under one year old.
- Denial of abuse, confident presentation or non-engagement should not be interpreted as absence of risk.
- Coercive control can mask vulnerability and requires specialist understanding and professional curiosity.
- Domestic abuse should be central to child protection planning, not treated as a parallel or adult-only issue.
- Failure to use specialist domestic abuse pathways and multi-agency risk forums can limit understanding of risk to children.
- Effective safeguarding requires integrated adult and child responses, including health, police, social care and specialist domestic abuse services.
- Persistent, trauma-informed engagement is essential where victims are unable or unwilling to engage, while maintaining accountability for child safety.

Families Who Move

The national review highlights that frequent and unplanned movement between areas can significantly increase safeguarding risk, particularly for unborn babies and infants. In Victoria Marten's case, repeated relocations across local authority boundaries were closely associated with escalating risk, persistent non-engagement and concealment of pregnancy. These moves disrupted continuity of professional oversight and made it increasingly difficult for agencies to maintain a shared understanding of risk.

The review identifies that safeguarding systems are often insufficiently equipped to anticipate or respond to families who move repeatedly, especially where residency is unclear or transient. Delays, incomplete transfers and lack of multi-agency discussion can result in critical safeguarding information being lost or diluted. In Victoria's family, moves coincided with key safeguarding

moments, including pregnancy and court proceedings, limiting opportunities for coordinated planning and intervention.

A central message for safeguarding partners is that movement should not be treated as a neutral or purely administrative issue. Where families with known vulnerabilities move frequently—particularly during pregnancy—this should trigger proactive, multi-agency safeguarding responses. Robust information sharing, clear accountability and anticipatory planning are essential to ensure unborn babies and infants do not become invisible to services.

Key points for safeguarding partners

- Frequent or repeated moves can be a significant indicator of safeguarding risk, particularly during pregnancy.
- Movement may reflect attempts to evade professional oversight or a trauma-related "flight" response and should be actively explored.
- Poorly managed transfers between local authorities can result in loss of critical safeguarding information and professional judgement.
- Clear, formal multi-agency processes are required to agree responsibility and maintain oversight when families move.
- Unborn babies are especially vulnerable where pregnancy is suspected but residency is unclear.
- Safeguarding systems should anticipate future moves and have up-to-date chronologies, summaries and contingency plans ready.
- National and local alert and information-sharing systems must be used consistently to prevent vulnerable babies from remaining unseen.

Recommendations – summary

The national review sets out a clear call for **systemic change** rather than isolated practice fixes. Its recommendations are aimed at government, safeguarding partners and inspectorates, and are designed to strengthen the protection of unborn babies and infants by shifting safeguarding systems from reactive responses to proactive, preventative and relational approaches.

A central message is that safeguarding unborn babies cannot rely solely on children's social care or on crisis-driven intervention. The review emphasises the need for **whole-system responsibility**, integrating adult services, criminal justice, health and voluntary sector provision, particularly where parents have experienced trauma, domestic abuse, serious offending or repeat child removal.

For local safeguarding partnerships, the recommendations focus on assurance: whether pre-birth practice is robust and consistent, whether non-engagement is actively addressed rather than tolerated, whether MAPPA and MARAC arrangements prioritise child safeguarding, and whether families who move are protected through clear accountability and effective information sharing. The review makes clear that leadership, scrutiny and culture are as important as process.

Key points for safeguarding partners

- Safeguarding systems must **anticipate risk**, including future pregnancies, rather than responding only once harm has occurred.

- Multi-agency **pre-birth protocols** should be in place, consistently applied, and focused on vulnerable unborn babies, including where pregnancy is concealed.
- Parental non-engagement should trigger **multi-agency reflection and problem-solving**, not drift or parallel working.
- A **Think Family** approach is required, integrating adult services (mental health, domestic abuse, substance misuse, housing and criminal justice) with child safeguarding.
- Support for parents should **extend beyond care proceedings**, to reduce repeat removals and future risk to unborn children.
- MAPPA and MARAC arrangements should treat **child safeguarding as core business**, including where offenders are managed at lower thresholds.
- Systems for families who move must ensure **clear accountability, timely transfer of information and preservation of professional judgement**.
- Safeguarding partners should use **scrutiny, audit and data** to assure themselves that these arrangements are working in practice, not just on paper.
- Inspectorates are expected to align frameworks to reinforce these priorities, increasing accountability for system-wide safeguarding effectiveness.