THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

7 MINUTE BRIEFING

Vulnerable babies: Pre-birth planning

LCPSR: CHILD C

This case study is about a premature newborn who died from non-accidental injuries and aims to share important learning about pre-birth planning and safeguarding newborn babies.

April 2026

1 About the family

Child C was a premature baby born at 33 weeks' gestation who died at two weeks old in a Special Care Baby Unit from non-accidental injuries.

Child C's family were White British and were known to multiple agencies prior to birth.

The mother was a care-experienced young woman, known to services in childhood due to neglect and physical abuse, and supported by the Leaving Care Service around housing and pregnancy.

The father, older than the mother, was known to Children's Social Care and CAMHS, had a diagnosis of ADHD, and was known to police and MARAC in relation to domestic abuse.

2 Background

Prior to Child C's birth, the unborn baby was subject to a Child Protection Plan under neglect, and Public Law Outline had commenced. Children's Services were planning care proceedings and a dual care plan at birth while further assessments were undertaken.

Key concerns included housing instability and homelessness, domestic abuse, parental mental health need, and inconsistent engagement

During pregnancy, the mother disclosed low mood and anxiety and was offered mental health support, which she declined. The father had limited engagement in mental health support.

Following Child C's sudden premature birth, risks escalated as did stressors, including homelessness, concerns about the father's behaviour, parental mental health worries, and caring for a medically vulnerable baby.

The parents attended hospital the night before Child C's death with all their belongings, after being asked to leave family accommodation due to concerns about the father's behaviour.

3 Patterns and practice

The case highlighted the challenge of ensuring risk assessment keeps pace with rapidly changing circumstances, particularly following a premature birth and increasing stressors.

Domestic abuse, including potential coercive and controlling behaviour, was a recurring concern, yet formal domestic abuse risk assessment tools were not completed, and disclosure schemes were not used. Safeguarding responses were not consistently informed by observable behaviour or emerging patterns.

There were missed opportunities to see and speak to the mother alone during pregnancy and hospital admissions, despite professional awareness of domestic abuse risk.

Concerns about the father's behaviour towards professionals, family members and the baby were noted but not consistently brought together into a shared, multi-agency assessment of risk, particularly within the hospital setting.

Wider family members raised concerns and offered support, but this was not progressed early due to engagement and consent challenges.

Information about the father having an older child from a previous relationship was disclosed but not fully explored or triangulated during pre-birth planning.

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Acknowledging good

The Leaving Care Service recognised the mother's vulnerabilities as a care experienced young person and made a timely referral to Children's Services. They continued to support engagement by attending meetings and undertaking joint work with other professionals, particularly in relation to housing and pregnancy.

Health professionals responded to disclosures of low mood and anxiety by referring the mother to enhanced midwifery support for women with additional vulnerabilities.

A Section 47 enquiry was undertaken following assessment, enabling multi agency planning. Parallel planning took place prior to birth, including consideration of post birth care and wider family.

A multi agency pre birth planning meeting was convened when premature birth was imminent, and practitioners sought to understand and include the father within assessment and planning.

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Key learning

Safeguarding plans for unborn and newborn babies need to be dynamic and responsive, with ongoing re analysis of risk as circumstances change, particularly during the immediate post birth period.

Housing instability and homelessness should be treated as safeguarding risks requiring active multi agency oversight.

Domestic abuse, including coercive and controlling behaviour, needs to be assessed using recognised tools and informed by behaviour and patterns, not reliant on disclosure or engagement.

There needs to be shared clarity about post birth observation and supervision arrangements, including oversight and escalation, particularly in hospital settings.

Early exploration of extended family as protective factors.

Hospital staff should be fully informed of the legal status and safeguarding plans for the baby and be supported to act as active safeguarding partners.

Pre-birth and newborn safeguarding should consider how race, ethnicity, culture or language may affect identification of risk, engagement during pregnancy, and access to support in other cases.

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Reflective questions

- How do I ensure safeguarding assessments actively change when circumstances shift, particularly following birth and where a baby is premature or medically vulnerable?
- Am I analysing patterns of behaviour and escalation, or relying too heavily on engagement and reassurance?
- How confident am I in identifying and responding to coercive or controlling behaviour, even when disclosure is limited or absent?
- Do I consistently create opportunities to see and speak with mothers alone, particularly where domestic abuse is a known concern?
- How do I ensure information from wider family members and other agencies is explored, shared and used to inform risk assessment?
- How do leadership, supervision and escalation arrangements support dynamic analysis of risk, particularly at key transition points such as birth or hospital discharge?
- How do I consider the impact of race, ethnicity or culture on pre-birth planning, engagement and decision-making, particularly where risks escalate around birth?

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Useful resources

Find more information about vulnerable babies on the Panel's new learning hub: www.childsafeguarding.independent-panel.uk

You can access videos, webinars, podcasts and other content, including the national review: Protecting all vulnerable babies better – National review into the broader safeguarding issues raised by the death of baby Victoria Marten

Read the full Local Child Safeguarding Practice Review: Child C, Somerset Safeguarding Children Partnership

Further learning is available:

- Pre-Birth Planning Toolkit - Somerset Safeguarding Children Partnership
- Born into Care: Best practice guidelines for when the state intervenes at birth