Kent Safeguarding Children
multi-agency partnership

Local Child Safeguarding Practice Review

"Marshall"[1]

Contents		
1.	Introduction	Page 1
2.	Process	Page 2
3.	Terminology used	Page 2
4.	Family Information	Page 3
5.	Analysis and identification of learning	Page 4
6.	Recommendations	Page 13

Introduction

1. The Kent Safeguarding Children Multi-Agency Partnership (the Partnership) agreed to undertake a Local Child Safeguarding Practice Review (LCSPR) to consider the learning that can be identified by considering the professional involvement with the family of a 9-month-old child called Marshall and their family[2]. Marshall died in April 2023. The pregnancy and home birth had been concealed by his parents and his mother did not have any ante or postnatal care. Marshall's birth was not registered, he was not registered with a GP and there had been no involvement of midwifery or health visiting in respect of him. At the time of finalising this report, there had not yet been an inquest, but it is believed that Marshall was a child with Trisomy 21 (Down's Syndrome) and the post-mortem found pneumonia, with a causal link to a heart condition.

2. It was agreed that a focused LCSPR would be undertaken, using details of the professional involvement with the family, to provide an insight into local systems and practice in respect of complex families, with many professionals involved with large numbers of children over at least the last 20 years, including siblings who are now adults and who are parents themselves.

3. The younger children living in the family home were not open to Integrated Children's Services at the time of the incident. Three of the older siblings had also been concealed pregnancies, and one had been booked significantly late.

4. Learning has been identified in the following areas:
    - The importance of all professionals working with one person in a large family, taking responsibility for checking wider records and updating systems and chronologies.

[1] "Marshall" is a pseudonym used to protect the family's identity.
[2] The family are white British and there is no learning identified in respect of race or culture.

- Family members can provide the child's voice and a valuable insight into their lived experience. When a family member shares information about concerns for a child, any ambiguities should be checked and triangulated.
- Working with families with a history of avoiding or misleading professionals.
- System-wide father[3] inclusive practice.

Process

5. An independent lead reviewer was commissioned[4] to work alongside a panel of local professionals. The process was outlined in a proportional Terms of Reference which focused on the most recent professional involvement with the family, while ensuring there was an awareness of the significant history. The panel met on a regular basis while the review was in progress.
6. The detailed information provided for the Rapid Review along with single agency reports completed for this LCSPR, provided the single agency information, reflection, and learning. Single agency recommendations were also made with action plans that were being completed as the review was undertaken.
7. A meeting was held with the professionals involved directly with the family prior to the child's death. This was well attended and provided the review with the opportunity to reflect on both the case and wider systems and practice in Kent.
8. The lead reviewer has spoken to both of Marshall's parents. Information was provided about the review, and they were asked to assist in identifying additional learning from their perspective. They requested that the engagement was by telephone rather than meeting face to face, and this was respected. The review thanks them for their time. Their views are included in this report.

Terminology used

9. The Kent child protection procedures have a section on concealed pregnancy which it is helpful to consider.[5] It acknowledges that there is no definition that is nationally agreed about what constitutes a 'concealed' pregnancy, However the procedures refer to it as 'a pregnancy that is not revealed until late in pregnancy, in labour or following delivery. The birth may be unassisted (no midwife) whereby there might be additional risks to the child and mother's welfare and long-term outcomes.' The procedures go on to say that a concealed pregnancy includes cases where 'an expectant mother knows she is pregnant but does not tell any professional, or when an expectant mother tells a professional but conceals the fact that she is not accessing antenatal care'. It is clear to the review that 'concealed pregnancy' is the appropriate term to be used in this case.
10. The procedures include a section on concealed pregnancies due to the increased risks associated with these children. The risks include potential health risks to mother and child not being detected antenatally, the health and development of the baby during pregnancy and labour won't have been monitored and any potential foetal abnormalities not detected, underlying medical conditions and obstetric problems will

[3] This should include all non-birthing parents living with, or having staying contact with, a child.
[4] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the Kent Partnership
[5] Concealed Pregnancies (trixonline.co.uk)

not be revealed, and an unassisted delivery can be dangerous for both mother and baby due to complications. It is also noted that a concealed pregnancy is an important indicator in predicting the risk of a future pregnancy.

Family Considered[6]

11. Agencies in Kent had extensive involvement with the family over a number of years, as Marshall has a large number of older siblings. At the time of Marshall's birth and then death the older siblings had services involved. Two of the older siblings (now adults) were receiving support from the Strengthening Independence Service for children/young people with disabilities (who provide services for those aged 0-25). Another sibling was allocated to the Integrated Children's Service (ICS) Adolescent Team and Children in Care Team and was then receiving support as a care leaver. A further sibling had also left care and was receiving support from leaving care services (Lifelong Links) and had extensive multiagency involvement because they had a child of their own who was in the care of the Local Authority. The younger siblings were attending school.
12. While Marshall was not registered with any services in his own right, a number of professionals working with the siblings were aware that Mother was pregnant and/or that she had given birth. There was just one referral to Kent's Front Door Service (FDS) via a 'Request for Support' in respect of the new baby. This followed the ambulance service attending the home of the paternal grandparent of one of the siblings. While there, the ambulance service was told that Mother had a six-month-old baby and that she required support. Mother was contacted by an FDS social worker and said that she did not have a baby. No further checks or actions were taken.
13. There had first been child protection concerns about the older children resulting in child protection planning in 2004. Since then, there have been recurrent lower-level neglect concerns, issues due to Mother's 'risky' partners, allegations of sexual and physical abuse, and contextual safeguarding concerns in the community for some of the older siblings. The school attended by the youngest of the children had cause to speak to their mother due to indicators of neglect in 2021 and 2022. School records include concerns that the child was 'dirty', 'unwashed', 'has nappy rash', 'has a sore/ red bottom and groin', and 'black fingernails and ears'. There were also concerns that the child was often 'quiet and withdrawn'. There was single agency learning from the LCSPR that the frequency of the concerns should have led to a clear written plan to be made with Mother for these concerns to be addressed, and if improvements were not achieved and sustained, a referral to the FDS would have been appropriate.
14. There is a history of specific concerns regarding Mother not receiving antenatal care and her and her then partners concealing pregnancies in 2007, 2009 and 2018. In all three cases she had home births and was then attended by the ambulance service who then took her and the baby to hospital. One of these pregnancies was the youngest child other than Marshall. Their birth led to a strategy meeting and a Child and Family Assessment. No ongoing safeguarding concerns were identified, and although early help was offered, the family said this support was not required.

[6] This report has been written with the intention that it will be published and only contains information about Marshall and their family that is required to identify learning.

15. Very little is known about the childhoods of either parent. When asked as part of the review, the parents did not disclose anything significant. Mother had some postnatal depression following the birth of one of her children, and some low-level mood documented on a number of occasions, reportedly due to financial pressures, but no other known mental health issue of note. She told the lead reviewer that two of her past relationships had been domestically abusive. It is known that Marshall's father has had some issues with his mental health and alcohol abuse in the past. He has children from a previous relationship. He told the lead reviewer of his sadness that he no longer has contact with them.
16. There is an on-going police investigation. The child siblings have been safeguarded and the older siblings are being supported.

Analysis and Identification of Learning

17. It is acknowledged that this is a complex case and that there were challenges for the professionals involved at the time including system issues, but also good practice. The older, now adult, siblings who were allocated in their own right were well known and supported by a number of professionals across agencies. There was good information sharing in respect of these young people and a commitment to meeting their needs as they became independent. There were also occasions where professionals such as health visitors and schools persisted to ensure that the children's mother engaged with them in the best interests of her children. On the whole however, the parents largely managed to avoid professional scrutiny and the children appeared to be guarded and cautious in speaking about their home life. It is significant that none of the school age children mentioned in class that they had a new baby at home. The teachers involved in the review reflected that this is very unusual. Overall, there was little real professional understanding of the younger children's lived experience, and few opportunities taken to gain their voices or the views of wider family members, including their father.

Learning Point: The importance of consulting genograms, chronologies and case summaries, that include information on all siblings, when making decisions, and of updating them when any new information emerges.

18. Following the previous concealed pregnancy, around five years before the birth of Marshall, it was recorded on ICS records for that child that there was a risk of further concealed pregnancies and that consideration must be given to a Request for Support being made followed by a Child and Family Assessment, if there was another birth in similar circumstances. This was not known to professionals in different teams and agencies, however. Knowing this systemic issue provides a challenge to partner agencies when considering how it can be ensured that this does not happen again.
19. A number of agencies had key documents such as genograms and chronologies on the records of the children in the family. With so many siblings with differing needs however, there was no one place where all of the information was held that could be accessed by anyone needing to understand the full history. There are also four different I.T systems that held social care records, including ICS, adult social care, early help, and the strengthening independence service. The family had the involvement of many agencies, some of whom remain involved and some of whom have closed their involvement due to thresholds or the children no longer requiring the service as they get older. This means there are practical

considerations and challenges to ensure responses to individual needs whilst also balancing and understanding the whole family system. In this case, each sibling tended to be worked with individually. There is evidence of good practice in the responses to the presenting needs of each child or young person open to ICS, but there was also silo working and a view that someone else would know and be doing something if there was anything to be worried about in respect of other family members who were not open.

20. At the time that Marshall died there were at least 20 different professionals directly involved with the other siblings. It is unrealistic to think that all these professionals and agencies would consult regularly, and it was not necessary for them to do so. It is also unrealistic to expect them to have a full understanding of the other professionals involved with other siblings of a different age or with different needs. The invisibility of Marshall however, shows that in large and complex families there is a need to think more widely than about the one child/adult sibling you are working with. To be able to do this, professionals should access the other sibling's chronologies and case summaries to ensure they are aware of key vulnerabilities and risks. They also need to take responsibility for updating systems when they receive a piece of information that is not reflected. For example, Marshall should have been entered as a 'relationship' to all his siblings by those working with the siblings and who knew about him. This would have meant that the duty social worker in the Front Door Service would have seen Marshall on Liberi and known that Mother had not been honest.

21. As stated in the single agency report submitted by Integrated Children's Services (ICS) the risk of concealed pregnancies was something which needed to be known by all of those working across the family. This should have included the information that serious consideration needed to be given to whether a Request for Support was required when it was identified by professionals involved with the older siblings that Mother was having another baby. There were also other issues within the family over the years that might indicate a need for support or indicate risk as the family grew. There were knowable concerns about Mother's partner (the father of Marshall) in respect of his drinking, his mental health, and allegations of abuse from some of Mother's older children. If the behaviour of some of the older children had been considered as a response to trauma and neglect, more questions may have been asked about the likely lived experience of the younger children still living with their mother. This case shows that when working with a child or young adult who no longer lives in the family home there remains a need to 'think family' when a new baby is expected or arrives, even (or particularly) if the younger family are not being actively worked with by ICS at the time.

22. A few days after the baby was born, one of the older siblings who was in the care of Kent County Council, told their social worker about the new baby and that there had been a home birth. At least two members of staff were aware of the baby and the Life-Long-Links worker met Marshall with both his parents at a home visit to discuss the family tree for a piece of work she was completing with the older sibling. The worker noticed that the baby potentially had Downs Syndrome, but this was not mentioned by the family. She reflected that there was nothing furtive about either parent, she had no suspicion that they were covering up the child in any way. She remembers discussing the existence of a new baby with the older

sibling's social worker and they agreed that there may need to be a request for support submitted to FDS in respect of the baby. This did not happen. There is no record of this conversation on ICS records, and while there was a record of the visit to the family home it does not say that Marshall was seen. Single agency learning has been identified about the need to ensure that case records are accurate and detailed, particularly in relation to case notes of home visits including who was present, and later conversations with colleagues which included the agreed actions and outcomes.

Learning: When concerns are shared by a family member, there is a need for professionals to be rigorous in ensuring that they are heard, that any issues or ambiguities are checked and triangulated with them, and that it is recognised that they can often provide the voice of children in the family.

23. The national review into the deaths of Star Hobson and Arthur Labinjo-Hughes "Child Protection in England" was published in 2022. Some of the learning identified in the review resonates for agencies and professionals in Kent, when considering professional involvement with Marshall, particularly the response to information shared by wider family members and their voices needing to be heard. The paternal grandmother of some of Marshall's siblings reported that she was caring for three of the children every weekend and for one of the children full-time when the ambulance service attended. She reported that Mother also had a 6-month-old child and that she needed support with the baby. The ambulance staff noted that the home was overcrowded and unkempt and put in a request for support to FDS in respect of these children, as well as the baby, who it was reported lived with its mother.
24. It was good practice that SECAMB submitted a request for support form to the front door, about both what they saw and what was reported to them. There is a process in place where health visiting is informed by SECAMB of any child under five coming to their attention. It did not happen in this case as the older children did not meet the criteria (they were all over 5 years old) and there was no detail of the name and date of birth of the six-month-old mentioned by Grandmother. If more information had been sought and recorded in respect of what the grandmother's concerns were for the baby and with more detail, such as the name and gender of the child, and the details of the child's father, this would have helped the FDS worker to be more questioning of Mother (and themselves) and enabled the information to be shared with health visiting. Neither SECAMB or FDS gave any consideration to the father of the older children or of the reported six-month-old baby. The review was told that at the time the FDS worker felt they had enough information to not follow up with the children's fathers, but that recent improvements in practice in including fathers and men living with children, will mean that this will now be applicable at the early stages of seeking information at the front door.
25. The FDS duty social worker who was given the task of contacting the children's mother told the review that Mother had been adamant that she did not have a baby. There was no exploration with Mother of why the grandmother might say there was a baby, and why she might have misled the ambulance service. No consideration was given to contacting the grandmother to clarify what she had said or to explore the other issues raised about the state of her home. No consideration was given to contacting the father of those of Marshall's siblings who had been identified by SECAMB, although it was him that the children were living with for part of the week at his mother's home. The duty social worker left it to Mother to monitor where her children were spending time, as they were reassured by Mother having no concerns

but agreed to ensure she checked all was well when the children were next due to visit. She was asked if she required support and Mother was clear that she did not. The social worker, having determined she had no consent to undertake any further work on the matter, discussed the matter with her manager (as is the process) and they agreed with the social worker that no further action be taken.

26. When exploring the response to the Request for Support with the FDS social worker during the review, they explained that they based their decision on the lack of child protection issues in the referral and their view that Mother was credible and believable. The information that was shared by SECAMB said 'possibly Mother may require support with her six-month old.' She also stated that Mother had phoned her back after she left a message, which apparently is unusual and encouraged optimism. The social worker did consider the most recent case history for the siblings still living with Mother and read about the last substantial piece of work with the family. This was a Child and Family assessment undertaken four years before, following the birth of the next youngest child. This was a significant episode, as it was due to Mother concealing her pregnancy and receiving no antenatal care. The Integrated Children's Services records did not have evidence of ongoing concerns once the assessment was completed however, and this reassured the duty social worker. They also noted that the assessment undertaken at the time suggested that Mother had not intentionally concealed her pregnancy and that there was a decision to take no further action. They were not aware that there had been two other births where Mother had not had antenatal care or of concerns from other agencies about Mother's avoidance of professionals. Research into concealed pregnancies stresses the risk of future pregnancies also being concealed, and this is outlined in the Kent procedures.
27. There was no consideration at FDS of why the grandmother might lie to SECAMB, no consideration of what other professionals who were involved with the family knew about a baby (particularly the allocated workers in ICS for some of the older siblings, who it is now known were aware of the baby), and no consideration was given to the fathers of the alleged baby or the older children. The social worker was clear that the lack of consent from Mother to pursue the issue further, the lack of child protection concerns from SECAMB, and, in their view, the lack of time and need to 'move cases along' in order to meet the timescales for consideration, all played a part. They said, 'we are expected to close contacts where there are no safeguarding concerns shared and no parental consent'. They did not consider the records of the older children who did not live with Mother, as they did not view this as proportional in the circumstances. It was clearly recorded on a number of agencies records that Marshall existed, including on a genogram completed for the child who was about to leave the care of the local authority. Marshall was not added to the system by those working with the older siblings, however. The information that was available was not identified by the FDS social worker. They told the review that they did not have consent and did not have time, and that they considered it to be disproportionate to cross reference to this extent. The time given to completing the initial work on a referral, 24 hours, are stipulated nationally in Working Together to Safeguard Children 2018. However, ICS has clarified that Kent County Council policy and guidance expects the exploration of family history and triangulation when making decision at FDS, with the option of further assessment in more complex cases. This did not happen in this case.

28. The review was told that social workers working in the FDS continue to predominantly work at home. This was an arrangement that started due to the response to COVID-19 and has continued. They are expected to attend the office 20% of the time – one day a week for full time staff and one day a fortnight for part time workers. In July 2022 Ofsted published a report 'children's social care 2022: recovering from the COVID-19 pandemic'. It raised concerns about the shift to hybrid working since Covid, with many staff now working from home more than they did previously. Ofsted were concerned, **nationally,** about what could be lost by limiting office work, stating that 'working together face to face creates opportunities for informal support and learning, and helps to maintain and boost morale. Social workers often encounter challenging and emotional situations, and it is important that they are able to talk through these with colleagues.' While there is evidence that more hybrid working is good for people's wellbeing and work life balance, there is a need to consider the impact on decision making of undertaking such a difficult job, from home. For new workers to the role, this is particularly essential. ICS told the review that they have been ensuring that FDS workers have the required support and connectivity when hybrid working, to ensure that the needs of children referred to the front door are met, and that what happened in the case of Marshall was not a reflection on working arrangements.
29. It is noted that no other professionals checked whether other agencies were aware of Marshall. This is because there was little knowledge of the previous unassisted home births and the knowable history of Mother concealing pregnancies, which may have prompted professional curiosity about Marshall. Marshall was not added to the 'relationships' section on any of the older children's ICS profiles. There was a change of ICS service for one of the older siblings which may have had an impact. He had been receiving social work support from the adolescent service but a transfer to the children in care service took place around the time that Mother would have been pregnant with Marshall. The adolescent service had been told by Mother's partner that she was pregnant in January 2022. They had concerns about this as the partner was known to be a heavy drinker, and they recognised that there may be a need to assess the parenting capacity of both parents with the increasing size of the family. When spoken to by a social worker in the adolescent service, however, Mother stated she was not pregnant. It is now known that this would have been the pregnancy with Marshall. When spoken to as part of the review, the manager of the new team that the older child transferred to stated she was not aware of the recent concerns about a possible pregnancy, and it did not appear to feature in any of the handover/transition records. Those newly working with the older sibling in the children in care service, who later knew about Marshall, were not aware of the concerns about Mother's partner or the previous concealed pregnancies. Improved practice in the wider system is required to ensure that family contacts, case summaries and chronologies are updated on I.T. systems to make it easier to quickly identify issues that may require deeper consideration.

    Learning Point: It is difficult to work with families with a history of avoiding or misleading professionals, particularly if the lack of engagement is not obvious.
30. When considering how engaged a parent is with the professionals who are involved, it is important to understand how consistent the engagement is and has been in the past, what might be stopping full engagement, and the impact on the children of a lack of meaningful engagement. Those who have

worked with Mother over the years have not particularly identified her as avoidant, being difficult to work with, or disingenuous. Case records of the contact with the family by Early Help in 2016, 2017 and then 2019 state that Mother (no partner was explicitly considered) was seen to be open with professionals and was happy to receive guidance, support, and referrals to other services. The Adolescent Team supporting one of the older siblings stated that Mother seemed to be cooperative and open with professionals.

31. The review has found, however, that there was evidence of unidentified disguised non-compliance[7]. Mother and her partners have not always been able to ensure that the children's needs are being met, and professionals needed to be cautious of relying solely on Mother's self-report and aware of the need to triangulate what she said with other professionals/agencies. For example, she told professionals that all the children had their vaccinations, but it is now known that this was not the case. One of the older siblings, who was in the care of the Local Authority had told their social worker that they had been drinking with Mother when they had been visiting the home, but that she had told them not to tell 'social services'. This was an example of Mother trying to influence her child's communication with professionals, and her willingness to be dishonest and encourage her children to do the same. There were other examples of Mother misleading professionals. Following her third concealed pregnancy in 2018, Mother initially told the hospital that she had had scans, she then said that she was not aware she was pregnant. She later told that child's health visitor that she intended to have a sterilisation so that she would have no further pregnancies. Mother was asked by the adolescent team worker if she was pregnant after Marshall's father had said she was, in 2022, and she denied it.
32. Mother also had a history of being difficult to engage with. For example, the health visiting service had difficulties in engaging Mother in respect of the child born prior to Marshall, who is now five years old. There was a pattern of Mother not being at appointments unless the health visitor persisted in contacting her, and of Mother not being truthful with the health visitor regarding the circumstances of the older child's birth, which was concealed. There was a total of three no access visits as well as one appointment being cancelled by Mother when the 9-12-month developmental check was required. The health visitor worked hard to ensure the check finally took place.
33. Single agency learning has been identified for primary care regarding ensuring that parents who do not respond to text message appointments for immunisations are pursued and the Was Not Brought policy used. There were missed or significantly delayed immunisations for most of the children in the family.
34. Professionals involved at the time of Marshall being taken to hospital reported that there was confusion and a lot of work undertaken because Mother had stated that he was registered with a GP and that she had lost the red book. Mother told the lead reviewer that she had tried to register her child's birth and to get a birth certificate for Marshall, but that this was not possible without a 'red book', which was not available because she had an unassisted home birth. It is a legal requirement to register a birth in the UK[8]. It is indeed expected that a parent presents the red book or hospital discharge papers when registering a birth. When a child has been born at home without a midwife present (like those families who choose a 'freebirth') it is necessary to contact the chief administrative medical officer of the Health

[7] Parents appearing to co-operate with professionals to allay concerns and stop professional engagement (Reder et al, 1993)[1].
[8] Notification of Births Act 1907

Board for the area. If the family had in fact contacted the Registrar, they would have been given details of what they needed to do.

35. Mother also said she had tried to register Marshall with a GP, explaining that she had again been told that it would not be possible to do so without a 'red book'. The review was told by Mother's GP surgery that if she had called the surgery to register the baby, she could have done so even without the red book, birth certificate or NHS number. There is a process in place which the surgery administrators are aware of and know how to complete. Mother stated that because of Covid-19, her GP surgery do not answer the phone or allow people to attend the surgery, and that she struggled to work the on-line systems in place on her phone. Marshall's father also confirmed this was an issue for him.
36. When asked what agencies could have done to have enabled her to seek antenatal care, Mother said that that she was very nervous of hospital births due to a close family member dying in childbirth. This did not account for her first two concealed pregnancies which were prior to this death however, although it is likely the trauma had an impact on her afterwards. This shows how important it is for professionals to have the full history and to be mindful of patterns that may pose a risk. This will avoid false reassurance and enable challenge when it seems that a parent is not telling the truth.
37. Mother was asked if there were any professionals that she could have spoken to about her wish to register the birth and get a GP for Marshall. She said that there was no one, because all the professionals she knows have left, sharing her view that the family get 'passed around'. Mother was specifically asked about the telephone call from FDS when Marshall was around six months old. She stated that she remembered the concerns about the children staying with their grandparent but denies she was asked about the baby. She said that it did not occur to her to ask for help with registering the child's birth or with a GP at the time.
38. Father said that he had not been concerned about the lack of professionals involved and did not think about the birth needing to be registered, stating 'I am a bloke!' Both parents were not worried about Marshall having a disability. Mother was not convinced he did, although 'people in the playground' had mentioned it. Father said that as far as he was concerned, Marshall just needed the love and care of his family. They both said they were not aware that babies with Down's Syndrome may have underlying health conditions that required monitoring and treatment.
39. A report published in the Child Abuse Review called Detecting Parental Deception in the Child Safeguarding Context by Leah Fox[9] notes the difference between those who deceive professionals in order to cover up intentional harm they were causing their children, and those who deceived because they were reluctant to be open with professionals for perceived less sinister reasons, including the possible concealment of poor parenting, which can led to a concern that their children may be taken away. In the case of Marshall, his mother, and perhaps also his father, probably knew from many years of involvement, that professionals did not communicate with each other, so they could be confident that they could keep the existence of Marshall from those who would wish to monitor his care. They were right.

[9] https://onlinelibrary.wiley.com/doi/full/10.1002/car.2727

Learning: The need to think about the likely lived experience of a new baby, and the impact of a baby on the older children.

40. Those working with the older siblings told the review that there was no obvious reason for them to consider if Marshall was known in his own right to the professionals who would be responsible for his care, such as a GP and a health visitor. None of them were aware that Mother had previously concealed pregnancies. All of those who saw Marshall and spoke to Mother about him stated to the review that she made no attempt to cover up his existence, spoke openly about having a home birth, and seemed comfortable with the professionals acknowledging his existence. There is no evidence that Marshall's father was spoken to by any professional. When Marshall was taken to hospital following his death, Mother told the hospital staff and then the police that she had registered him with a GP and that she had 'lost' his red book. Learning about parents lying to professionals has been identified in many reviews, from Climbē in 2003 to Star and Arthur in 2022. Fox's 2021 report provides a literature summary about professional practice and distinguishing between truthful and deceptive behaviours by parents. It acknowledges that parental deception is 'a significant feature of everyday child protection practice'[10] and recognises that in their relations with professionals, parents sometimes are 'intentionally deceptive or manipulative'.[11] Those who met the parents and acknowledged Marshall were shocked to later hear that they had not received any medical support or advice and that Marshall was not formally known to any professional.
41. Those involved with the older siblings knew there was no on-going social care involvement with the younger children and assumed that this was because there were no concerns. However, there were **knowable** concerns about Mother's partner and the father of the baby (and possibly of the older child) including about his drinking. There had also been incidents of violence in the home between Marshall's father and one of the older siblings, and another of the older siblings had gone to live with their father and grandparents because of the behaviour of Marshall's father. The school also had some concerns about the care provided to the youngest of the siblings. Even without knowledge of Mother's history of concealing pregnancies, there was a need for those who knew about Marshall to think about whether there was a need to speak to other professionals.
42. Another issue that required curiosity and thinking wider than about one child, was that the older child who was in care was showing the impact of trauma and rejection through their behaviour, which may have been partially linked to there being a new baby in the home. The child had allegedly been violent in the past, including to Mother and her partner, and the impact on a new baby should have been considered as they were having extensive ongoing contact in the family home. Those working with the older sibling considered the impact on this young person of the pregnancy and new baby, but not the other way round.
43. A police officer 'met' baby Marshall. They had cause to visit the family home on an unrelated matter that involved the adult siblings. When they attended the address Mother was holding a 'newborn baby'. The officer remembers having a conversation about the baby as the officer had just returned from maternity leave themselves. Mother said she had a home birth and acknowledged that the bottle of milk she was

[10] Tuck, 2013
[11] Laming, 2009

feeding the child with was small as they had been born early. The officer did not think there was any reason to be suspicious or concerned. They were not aware of any family history.

44. One of the older siblings was seen by a public health nurse at the family home (they were visiting their mother at the time) and the nurse saw baby Marshall in a car seat. The home was described as exceptionally busy, but there were no safeguarding concerns for the new baby or any of the other children present. The nurse spoke to the older sibling's social worker in the Strengthening Independence Service and updated her on the contact, including noting that Mother had a one-month-old baby. This discussion was noted in the older siblings ICS record, but the baby was not added to the relationships on the ICS system, Liberi.
45. In all, 12 professionals were informed about the existence of Marshall or met him while visiting the home for other reasons. Mother was also seen with a pushchair in the school playground, although there is no evidence that any questions were asked about who the baby was by any school staff member. While the school had some lower-level concerns about the children, they did not feel it met the threshold for any enquiries in respect of the baby that Mother appeared to be caring for. The only professional interventions for Marshall himself prior to his hospital admission, were the limited request for support referral from SECAMB and the FDS telephone call to Mother.
46. **Learning point:** Increased understanding and involvement of fathers or non-birthing partners in families is required. This should include considering their history and their role within the family.
47. Father told the lead reviewer that he has rarely been spoken to by any professional in respect of his own child or the children of his partner who he lived with. Numerous reviews have identified that fathers/non-birthing partners are not generally considered as an equal parent by agencies when it comes to the children they live with or have contact with. There has been work in Kent to improve the engagement with and consideration of men. If a family agrees to a social work or early help response, the father/non-birthing partner is included in the assessment. It appears however that not much was known about Marshall's father and there was little professional engagement with him from the time that he commenced a relationship with Mother, despite concerns being shared by some of the older children and by the father of the children living with their mother.
48. As stated in the national review, '"knowing about and 'seeing' these men better is a crucial step in enhancing the quality of protection afforded to babies". There is a need for all professionals working with children to think about fathers (or stepfathers) from day one and making sure that they are core to the task. There needs to be an expectation that fathers engage with appointments about pregnancies or the children they are living with. As noted in the 2021 National CSPR, The Myth of Invisible Men[12], true engagement with and by a non-birthing parent continues to be seen as a bonus rather than an expectation and what is required. The father of Marshall would agree with the national review that men are 'bystanders' rather than fully involved in services being delivered to children and their mothers.

[12] https://assets.publishing.service.gov.uk/media/6141e34f8fa8f503bc665895/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

49. The Kent partner agencies have recognised that the lack of 'father inclusivity' is a factor in local CSPRs as well as national ones and is evident in a broad range of research. They are committed to improving father inclusion as an essential element of practice with children and families to ensure the wellbeing and safeguarding of children and young people. Kent has produced Father Inclusive Guidance and accompanying resources to support practitioners and service providers in taking an inclusive approach to fathers, which was published in September 2023.[13] This was after Marshall died, and the review was told work is being undertaken to ensure that the guidance has a positive impact on practice across agencies.

Conclusions and recommendations

50. Marshall was born into a family where there was a knowable history of concealed pregnancies and lack of engagement with ante and post-natal care and preventative child health. He had special needs that may have required treatment and monitoring. Those working with the wider family were focused on those that were their responsibility and did not effectively consider the needs of a new baby within this family. Those who asked Mother about Marshall were either reassured by her openness about him, or by her conviction that she was not pregnant or did not have a baby. As stated by the National CSPR panel in 2022, in their review Child Protection in England, 'complexity is a central feature of child protection work. It is what we are asking child protection professionals to cut through, to get to the truth of what life is like for children.'
51. Without a birth notification there was no opportunity for Marshall to come to the attention of the agencies who would have been responsible for his health and well-being. The system relied on the parents or other professionals working with the wider family to recognise he was here.
52. There has been relevant learning in other reviews undertaken in Kent. This includes the CPSR Mira (as yet unpublished) where there was limited agency engagement with the child's father. An anonymised report by area also found learning about the need to provide services that are inclusive of fathers. There are also several recent rapid review action plans with relevant learning, including in respect of working with families where there is a history of professionals not managing to engage with parents, and working with large and complex families. The recommendations included below have considered those already being completed by the Safeguarding Children Partnership and its partner agencies.
53. It is recognised that actions have already been taken in relation to some of the multi-agency and individual agency learning, and that changes have been made. Having considered further learning identified during the review, and recognising the need to check that the reported changes are effective, the following recommendations are made.

Recommendation 1:

The Partnership to ensure that the learning from this case, including the safeguarding procedures in respect of concealed pregnancies, are promoted via a learning and improvement briefing.

Recommendation 2:

[13] https://www.kscmp.org.uk/__data/assets/pdf_file/0008/158066/Kent-Father-Inclusive-Guidance-FINAL-Nov-2023.pdf

Integrated Children's Services to provide assurance to the Partnership about the hybrid model of working at the FDS.

Recommendation 3:

Partner agencies to provide information to the Partnership about their processes and procedures for completing chronologies[14] and case summaries to inform safeguarding work. They should also provide details of any plans to review this, considering the learning from this CSPR.

Recommendation 4:

Partner agencies to inform the Partnership about how they are assuring themselves, from their auditing activity, about improvements in father inclusive practice.

[14] It should be noted that chronologies should include positive information in respect of the family. They can be used as a tool for engaging the family and can include their comments and views.