Summary of "The myth of invisible men": safeguarding children under one from non-accidental injury caused by male carers

This briefing summarises findings from the Child Safeguarding Practice Review Panel's review of serious incidents involving babies under-one-year-old who have been harmed or killed by their fathers or other males in a caring role.

September 2021

Background to the review

The Child Safeguarding Practice Review Panel (the Panel) is an independent body set up to identify, commission and oversee reviews of serious child safeguarding cases in England. It brings together experts from social care, policing and health to provide a multi-agency view on cases which raise issues that are complex, or of national importance.

This review looks at the circumstances of babies under-one-year-old who have been harmed or killed by their fathers or other males in a caring role.

The review is informed by: interviews with eight male perpetrators serving prison sentences for harming babies; in-depth research into cases involving 23 babies that have been notified to the Panel; a review of the research literature; and roundtable discussions and one-to-one meetings with key stakeholders.

This is the Panel's third national review (Child Safeguarding Practice Review Panel, 2021). It was published alongside the following supplementary resources:

- literature review (Davies and Goldman, 2021)
- fieldwork report, taking an in-depth look at 23 cases from 19 local areas (Walters, Wonnacott and Myers, 2021)
- psychologists' report into interviews with eight men convicted of killing a baby in their care (Godsi, 2021).

Key findings

Risk factors

The review uses information gathered from interviews with perpetrators, analysis of serious incidents and a review of the literature to identify the following potential risk factors:

- Men whose own parents were abusive, neglectful or inconsistent. This can result in poor attachment styles as adults and inappropriate responses to the needs of children.
- Men who have histories of impulsive behaviour and low frustration thresholds.
- Men who abuse substances, especially drugs, to a degree that encourages increased levels of stress and anxiety, sleeplessness, lowered levels of frustration tolerance, heightened impulsivity, poor emotional and behavioural regulation and poor decision making.
- Men who have low self-esteem, or other issues around mental and emotional health.
- Men who become parents at a young age, including care leavers.
- Men who mitigate their difficulties with others through violence and controlling and angry behaviour, including some who are perpetrators of domestic abuse.

- Men experiencing external pressures such as those brought about by poverty, debts, deprivation, worklessness, racism and poor relationships with the mothers of the children.

Inflicted injuries often occurred during a time of heightened stress. Significant relationship problems were common, within a spiralling negative cycle of drug abuse, deterioration in mental state and poor decision making, and a lowering of frustration threshold. The injuries inflicted on the baby were often triggered by normal infant behaviour, such as crying or being sick, in the context of a mixture of the risk factors identified above.

Information sharing

The review identifies lack of information sharing as a key factor that prevented practitioners from seeing and responding in a timely way to risk to babies.

Three key issues were identified:

- A lack of patient record integration across the health service, most noticeably in communication between midwives, health visitors and GPs. Some risk factors may only be known to GPs and they require the consent of the father to share information with others. Health records for babies only allow the inclusion of one adult (the mother), so records relating to fathers are held separately and family records cannot be seen in a joined-up way.

- GDPR was seen by many to have made information sharing less effective and more complex. It was seen to limit professionals' ability to use pre-birth protocols and procedures to trigger assessments. Decisions about whether the threshold of Section 47 has been reached can only be made if all relevant information is known, but the information can only be shared once the threshold has been reached.

- Practitioners were unclear about thresholds for sharing information and referring cases into the Multi Agency Safeguarding Hub (MASH).

The review also found that legislation and guidance was in place to enable information sharing, but organisational culture and leadership caused variation in how well this happened in practice.

Service response

Many of the families involved in the reviewed cases never had access to specialist support, but were reached by universal and early intervention services.

However, services covering the antenatal and early months of life in England remain predominantly women-facing, and are less accessible to fathers. For example, antenatal services are rarely provided out of hours or at weekends and aren't designed to maximise fathers' involvement. As a result, fathers are not provided with important information about becoming a parent, such as the impact of crying and how to feed and handle babies safely.

Cuts to funding mean that there has been a decline in the provision of early intervention services, and services that are provided don't have the capacity to target fathers. This means that the potential to use impending fatherhood as a "reachable moment" is often lost. There is a reduced ability to identify men whose vulnerabilities might require further specialist input and it is less likely that the risks they may present to their child are identified and acted upon.

Men were also often only partially seen by statutory children's services, particularly children's social care. Engagement with fathers is often characterised by shallow assessments and weak engagement, and services often do not know who fathers are nor the risks they present.

There was also often insufficient linkage between children's and adults' services. Where there is evidence of clear and present danger to children referrals are made, but where risks are less well defined they aren't. Thresholds and prioritisation of limited funds means adults with some mental health needs or less serious substance misuse issues do not receive a service. However, adults who present a lower level of need to adult provision can present the highest level of need to children's services. Programmes aimed at perpetrators of domestic abuse are not universally available and where they exist the impact on the safety and wellbeing of children is insufficiently evaluated. Programmes often focus on challenging men about their behaviour and the risk they post to adults, but do not consistently challenge them on the risk they pose as fathers.

Improving engagement and assessment of fathers

The review identified a four-tiered approach to improving the engagement and assessment of fathers:

- Understanding men's lives and their experiences: to assess and engage with fathers effectively practitioners first need to understand each man's individual context and background.

- Engaging and assessing men: fathers' histories and personal circumstances should inform the development of parenting strategies and help practitioners explore issues with fathers like how they deal with frustration and anger, tolerance of unexpected demand and, where needed, work around substance misuse and emotional wellbeing. Practitioners need to address men's

understanding of the emotional and developmental needs of babies and children and help them explore what good parenting looks like.

- Supporting best practice: supervisors and those overseeing frontline practice need to ensure that the assessment and engagement of fathers is evident within the work of their frontline staff. Children in need and child protection planning should maximise engagement of fathers.

- Service design: safeguarding partners and system leaders need to set the necessary conditions within which work with fathers is enabled and expected. To do this they need to address challenges around context and culture; processes; and tools, frameworks and services.

Recommendations

The review identified recommendations to improve the response to fathers:

- Government funding must be provided to enable local areas to develop models of good practice in working with fathers.

- Pilot areas must be identified and funded by the government to develop holistic work with expecting fathers who meet the risk factors outlined in this review, in a collective and integrated service response.

- Research must be commissioned by the government to enable a better understanding of the psychology and behaviour patterns of men who have abused babies through non-accidental injury.

- The engagement of fathers must be embedded in prospective and current programmes such as Family Hubs, the Troubled Families Programme and follow up work to the Leadsom Review into the first 1,000 days.

- Future inspections carried out by Ofsted, CQC and HMICFRS must assess the extent to which agencies are responding to the findings of the report.

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