

# “The Myth of Invisible Men”

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Safeguarding children under 1  
from non-accidental injury caused  
by male carers

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# Foreword

The circumstances of the babies considered in this review are, without exception, profoundly disturbing and distressing. During the course of their very short lives, they experienced unspeakably terrible injuries and abuse. Some died as a result and some of those who survived face a lifetime of impairment and life limiting health conditions.

We have chosen to look at serious incidents in which men are the perpetrators of this type of abuse, and who most poignantly, are predominantly the birth fathers to the children whose cases we reviewed.

Safeguarding practice with fathers of young children is something of a paradox. Despite evidence suggesting some men are very dangerous, service design and practice tends to render fathers invisible and generally 'out of sight'. The report's title: 'The Myth of Invisible Men' reflects our resolve to get behind this paradox so that work with fathers might become less ambiguous and more effective.

There is an undoubted imperative to extend our knowledge base about men who physically abuse babies. Firstly, there is a need to seek greater and more nuanced understanding about their lives and behaviours, including about factors that may have precipitated the abuse. Secondly, we must take stock of how effectively safeguarding and other services engage with these men. What emerges is a hazy and incomplete picture, in part because we do not 'see' them or understand them well enough or in sufficient detail.

The review has sought to strike a balance between understanding the impact of their life circumstances on how these men have parented and cared for their children whilst not in any way diminishing the gravity and seriousness of their actions. Knowing about and 'seeing' these men better is a crucial step in enhancing the quality of protection afforded to babies .

Many of the issues explored here reflect deeply engrained roles, stereotypes and expectations about men, women and parenthood in our society. Notwithstanding major social changes, women continue to be regarded as the prime and sometimes only protective carer for their children. Some men struggle to articulate their fears and anxieties about fatherhood, may be poorly prepared for its demands and resort too quickly to violence, creating very significant risks to children in the situations considered here.

The report also takes stock of how well safeguarding and other services engage with men. It sets out systemic weaknesses in the way that universal and specialist services operate. Too often, even if unwittingly, they enable men to be absent. Importantly, services do not maximise opportunities to identify and respond to the vulnerabilities and risks that some men can present. Some of the men in this review wanted to remain hidden, unassessed and unengaged. Others were keen to be good fathers but were ill

equipped in terms of skills and resilience. It is the prime contention of this review that the way safeguarding and related services operate makes it far too easy for them to remain 'invisible' and 'not engaged'.

The findings and conclusions of this national review are far reaching, challenging and will not be straightforward to address, but they must be tackled with due resolve and tenacity if we are serious about better protecting babies from abuse and violence. The Panel's role of providing a 'window on practice' requires that we call out ways in which the culture, organisation and delivery of services can get in the way of our very best intentions of protecting children. The report recognises that government has a number of initiatives underway to support parenting – it is vital that we use these opportunities to make sure that policy and practice has a strong focus on fathers.

This review has benefitted from some skilled and experienced input from four reviewers. I am very grateful for their insights and commitment. Alex Walters, Jenny Myers and Jane Wonnacott worked with practitioners and managers in the 23 fieldwork sites, speaking to over 300 safeguarding leaders and practitioners, producing a valuable overview report. A consultant clinical psychologist, Elie Godsi, led on interviews with male perpetrators and his analysis forms a central part of this review, providing insights and information about the views and lives of the men. Participating in these interviews is unlikely to have been straightforward for the men concerned and it is important to recognise that their perspectives have been crucial in shaping the review's conclusions. The Ministry of Justice and individual prison governors and staff (in particular, prison offender managers) were very helpful and supportive in facilitating those interviews. The Fatherhood Institute delivered a comprehensive and detailed literature review that has enriched this report.

We met a substantial number of people during the course of this review, either in one-to-one conversations or in roundtable meetings – they are too many to list but I am grateful for their time, thoughts and the energy that they brought to those conversations. The Panel Secretariat have proved tireless in their support and assistance and whilst a number have been involved, Felicity Winter and, most especially, Michelle Sharma, have contributed immeasurably to this report. Finally, I would like to thank the two Panel members who have worked on this review, Karen Manners and particularly Mark Gurrey, who has shown unceasing determination and commitment as review lead, to make sure that this work is well placed to make a tangible difference across the safeguarding system so that babies might be better protected.

**Annie Hudson**

Chair, Child Safeguarding Practice Review Panel

## Executive summary

This is the third national review commissioned by the Child Safeguarding Practice Review Panel (the Panel). It focusses on the circumstances of babies under 1 year old who have been harmed or killed by their fathers or other males in a caring role. 35% of all serious incident notifications involve serious harm to babies, the vast majority involving physical injury or death. This is the biggest category of all notifications that the Panel sees.

In the majority of cases where babies have been injured or killed, men are the perpetrators – research suggests that men are between 2 and 15 times more likely than women to cause this type of harm in under 1s. The greater prevalence of male abusers sits alongside a description of men as too often being 'hidden' or 'invisible' to safeguarding agencies.

The specific questions this review seeks to answer are:

'Looking at cases of non-accidental injury (NAI) in infants under the age of 1, how well does the safeguarding system understand the role of the father/male carer?'

'How can the safeguarding system be more effective at engaging, assessing and planning for and with men in the protection of children (or those for whom they have a parenting responsibility)?'

The review consisted of four key elements:

- i. Interviews with eight male perpetrators who are currently serving a prison sentence for harming babies.
- ii. In-depth fieldwork research into cases involving 23 babies that have been notified to the Panel, holding meetings with 322 practitioners and managers.
- iii. A review into the research literature.
- iv. A series of roundtable discussions and one-to-one meetings with key stakeholders.

The report from the interviews with the men along with the fieldwork report are published alongside this review. The literature review is available on the [Fatherhood Institute's website](#).

The evidence gathered during the course of this review highlights an urgent need to improve how the system sees, responds to and intervenes with men who may represent a risk to the babies they are caring for. For this group of men, the role that they play in a child's life, their history of parenting and their own experiences as children and how this effects them as adults, are too frequently overlooked by the services with responsibilities for safeguarding children and for supporting parents.

There is evidence that universal services, such as midwifery and health visiting, during the periods before and immediately after birth, do not regularly, significantly and substantially involve fathers. This then appears to set a pattern in practice which is replicated throughout targeted and specialist services, and into the family courts. The opportunity for offering support to men who might need it in their role as fathers, for early identification of both parental and children's vulnerabilities, and potential risks that these indicate, are not maximised.

The review concluded that there are a number of contextual factors linked to NAI to infants and that their interaction heightens the risk of abuse. It identified the significance of men who have had a background of abusive, neglectful or inconsistent parenting themselves, which can lead to poor mental health, often exacerbated by:

- Substance abuse, especially use of drugs, which can encourage increased levels of stress and anxiety, sleeplessness, lowered levels of frustration tolerance, heightened impulsivity, poor emotional and behavioural regulation and poor decision making.
- The co-existence of domestic abuse and the fact that some men mitigate their difficulties with others through a rapid default to violence and controlling behaviour.
- Living with the pressures of poverty, mounting debts, deprivation, worklessness, racism and, in several cases for the men we spoke to, very problematic relationships with the mothers of their children.

It is vital that services better understand how these factors can impact on the ability to parent safely and at different stages of a child's life. The extreme vulnerability of babies under 1 needs to be explored in depth with both parents (regardless of whether they live together or are in a relationship with each other) as well as with other new partners. This builds a shared understanding about how adult needs interact with parenting, how they may manifest in particular situations, and how possible risks to babies can be mitigated.

This review identified some all too familiar difficulties in the safeguarding system, most notably problems associated with information sharing, both within different parts of the health service and across the wider safeguarding system. The Panel will continue to contribute to cross government work in this area.

The report outlines a series of challenges to safeguarding partners as well as a four tier model to help leaders and practitioners develop a full understanding of the history and personal circumstances of fathers and to develop more detailed and balanced assessments and engagements thereafter. The report calls for investment in three areas.

Firstly, there needs to be more **research into male perpetrators of abuse against babies**, to explore their psychology and background, to develop and add to the understanding we have gained to date. There is a need to build a body of knowledge about these abusers so the safeguarding system can respond more effectively to the risks babies may face.

Secondly, there needs to be investment in developing **provision within children's social care** to improve practices with men and fathers within high risk families. Children in need and children on child protection plans are most at risk and there needs to be greater confidence that the responses to them are addressing all the risks they are facing, including from their fathers and father figures. As an example, strengthening the family safeguarding model to include a specific strand of work with fathers would build on a model that is already addressing a number of the issues identified in the review – in particular the importance of working with both adult and children's services.

Thirdly, there should be **investment in local pilots** to develop end-to-end system change, from universal through to specialist services including those involved in care proceedings. This necessarily should include domestic abuse, substance misuse and mental health services, and explore different ways of working with men and fathers to address the issues raised by this review.

This report acknowledges some of the important work already going on in supporting families with babies and **recommends work to ensure that they fully explore and evaluate how best to engage and work with men**. Five major policy developments are already in place which, with relatively minor changes, could address issues raised by the review. These are:

- 'Best Start for Life: A Vision for the first critical 1001 days (The Leadsom Review)'.<sup>1</sup>
- The associated development of Family Hubs.
- The 'Supporting Families 2021-22 and Beyond Programme' which is the next phase of the Troubled Families Programme.<sup>2</sup>
- 'Better Births' which focusses on the modernisation of the midwifery service.<sup>3</sup>
- The implementation of the Domestic Abuse Act 2021, especially the focus on perpetrators.<sup>4</sup>

The central tenet of this report is that those leading and commissioning services and practitioners who deliver them should do more, much more, to make the seemingly invisible, visible, and the hidden, known. More must be done to offer the necessary support, challenge and engagement with the men with whom practitioners work, or

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1 [The best start for life: a vision for the 1,001 critical days – GOV.UK](#)

2 [Supporting Families – 2021-22 and beyond – GOV.UK](#)

3 [National Maternity Review Report \(england.nhs.uk\)](#)

4 [Domestic Abuse Act statutory guidance – GOV.UK](#)



with whom they should be working, in order to prevent more babies suffering serious injury or death.

# Introduction

# 1. The review question

- 1.1. The need for this review is pressing. During 2020, the independent Child Safeguarding Practice Review Panel (the Panel) received 482 Serious Incident Notifications (SINs) relating to 514 children; 35% of these concerned babies under 1 year old. Since its establishment in July 2018, the Panel has considered 257 rapid review cases of babies under 1 year old, seriously harmed or killed through non-accidental injury. Significantly, in these cases, men (fathers and stepfathers) were a greater source of physical abuse to these babies than their mothers.
- 1.2. Babies – the most vulnerable of all children – face the greatest risks. Every life lost is an incalculable tragedy, for the child, their family and also for everyone, including professionals, who have known them. The Panel, safeguarding professionals and government have a clear responsibility to make sure that there is a deeper understanding of what happened to these children, and what should be done differently to protect babies better in the future.
- 1.3. It was clear at the outset that a single review could not do justice to all the many facets and complexities of the circumstances in the lives of these babies. The Panel therefore decided to focus on the role of fathers and father figures. The review explores the tension between, on the one hand, evidence that men are disproportionately perpetrators of this form of child abuse and, on the other hand, practice and research evidence that too often men are poorly engaged by universal services and safeguarding agencies. This is the paradox which needs to be resolved. Nationally, we are in what we consider to be an unacceptable position of knowing the least about those who present the biggest life-threatening risk to babies.
- 1.4. The review questions, as agreed with the Secretary of State for Education, were therefore:

‘Looking at cases of non-accidental injury (NAI) in infants under the age of 1, how well does the safeguarding system understand the role of the father/male carer?’

How can the safeguarding system be more effective at engaging, assessing and planning for and with men in the protection of children (or those for whom they have a parenting responsibility)?’

‘Invisible men’ is a term that comes up frequently in case reviews yet there has not been an in-depth and sustained exploration of why this is the case and what the consequences for children might be. Sometimes described as ‘ghosts’<sup>5</sup> and

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5 Brown, et al ‘Manufacturing ghost fathers: the paradox of father presence and absence in child welfare’ in *Child and Family Social Work* Vol 14

sometimes as 'shadows'<sup>6</sup>, the role of, and practice with men in the lives of babies who have been injured or died as a result of abuse has been strikingly neglected in safeguarding thinking and practice.

- 1.5.** This review focuses on acts of violence, often extreme, by men and which can have fatal outcomes for the babies involved. Although this review is concerned with acts of gross violence committed by men, it would be misleading to see this as being a review about 'violent men'. Whilst anger and low tolerance of frustration were identified by the review as key characteristics, their behaviour did not usually involve frequent and serious violence towards others. These men had not commonly had a lot of contact with criminal justice agencies such as the police, probation and prison service. As such, they had not been flagged as presenting a significant physical threat and risk to others, including children.
- 1.6.** This is an important feature and it highlights how professionals working with families should be wary of assuming that previously known violent behaviour is the only indicator that a father may struggle with the frustrations and challenges of parenting babies.
- 1.7.** A key theme of this review is that this group of men are too frequently overlooked and are poorly engaged by universal and specialist services, such as midwives or health visitors. This then appears to set a pattern that is evident through targeted and specialist services, including care proceedings. The opportunity for support and for early identification of both parental and children's vulnerabilities and real or potential risks are therefore not maximised. Too often men are either seen as 'good' and therefore to be actively engaged and entrusted with the care of their children, or they are deemed to be 'bad', to be kept at arms-length and, if possible, excluded from the family's life because of the safeguarding risks they present. This sometimes results in children being removed if their mother is unable or unwilling to see the danger that a man may present to children.
- 1.8.** These simplistic judgements tend not to apply to women. Mothers are more likely to be seen in a more rounded, holistic way, with their strengths identified and built on, areas of concern addressed and attention given to enhancing their support systems. In short, greater proportionate effort and attention is given to enable mothers to be the best parents they can be. This more nuanced approach does not generally underpin practice when engaging fathers. This has a catastrophic impact on some babies and was a key driver behind our decision to conduct this review.

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6 Ewart-Boyle et al 'Social work and the shadow father: lessons for engaging fathers in Northern Ireland' in *Child and Family Social Work* Vol 20

- 1.9. There is some evidence that the rate of SInS relating to abuse to babies increased during the COVID-19 pandemic (2020-21) but the rise does not seem to be significant when seen over a longer time frame. A considerable amount of research and analysis has now been produced on the effects of the pandemic on families and on vulnerable children and how the safeguarding system has responded. The Panel has produced its own analysis contained within its [annual report 2020](#). We have not reiterated any of those findings here.

## 2. Methodology

### 2.1. The review consisted of four key elements:

- Interviews with eight men who have been found guilty of killing or causing serious harm to a baby and are currently serving a prison sentence. These men were either responsible for the harm caused in the fieldwork cases we looked at (see below) or other cases presented to the Panel or the subject of recent Serious Case Reviews (SCRs). A consultant clinical psychologist with experience in this field designed and carried out the majority of the interviews. The interviews sought to explore the men's experiences of their own childhood, the parenting they received, their attitudes to family life and parenting, and their experiences of professionals and agencies. They also explored, as far as they were able or willing, the moments leading up to, and including, the abuse itself. The overview report from these interviews is published alongside this review.
- Fieldwork research conducted by experienced Panel reviewers, looking at cases involving 23 babies. All 23 cases had been subject to a rapid review and had been presented to the Panel. Thirteen cases had progressed to be either SCRs or Local Child Safeguarding Practice Reviews (LCSPRs). There was a broad geographical spread of these cases across the country. The reviewers met 322 involved practitioners and managers, but as many of the cases were subject to either criminal or care proceedings, it was not possible to interview as many family members as intended. The summary report of the fieldwork is published alongside this review.
- A literature review carried out by the Fatherhood Institute; this is also available as a separate document.
- A series of roundtable discussions and one-to-one meetings with key stakeholders; these were helpful in testing out the review's emerging thinking and for seeking examples of good practice relevant to the review.

# Key findings

## 3. Findings

- 3.1.** This section presents the findings as a series of interconnected issues; these are:
- What incidence data highlights about patterns in situations where children have suffered serious harm or died as a result of NAI and where their fathers (or sometimes stepfathers) are the identified perpetrators.
  - What we can learn from the review's interviews with men convicted of abuse about their individual histories, behaviours and psychologies, and how these affected the abuse they perpetrated.
  - What was happening in the immediate period prior to the abuse, including how these men managed their anger and their low frustration thresholds.
  - The co-incidence of the abuse with domestic abuse, substance misuse, mental ill-health, parents being young and/or who are care leavers.
  - How contextual issues (such as race and ethnicity, culture and poverty) may have affected what happened.
  - The effect of the perennial problem of good information sharing and informing seeking.
- 3.2.** This report suggests that, if we are to respond better to the safety needs of babies, these interconnected issues must all be recognised, understood and addressed together. Collectively, these are the factors that impact upon the lives of families looked at in this review and the safeguarding system needs to respond to them coherently.



## 4. Incidence data

- 4.1.** Research in this field is not extensive, especially within the parameters of this review; a focus on male perpetrators, children under 1 year old and physical abuse as the source of harm. However, there are some important headline data:
- Perinatal neonaticides (homicides within 24hrs of birth) are almost exclusively perpetrated by birth mothers.<sup>7</sup>
  - Between 2000 and 2015 in England and Wales, 122 babies were killed by fathers (11 of these by step-fathers) giving an average of eight infants per year killed. Of these, 31 died as a consequence of shaking.<sup>8</sup>
  - In the only UK analysis we found, covering convicted homicides in England and Wales over the period 1997-2006, infants were more likely to be killed by a father (as the main perpetrator) than by a mother in the approximate ratio 2:1.<sup>9</sup>
  - Biological fathers are more likely to kill infants than stepfathers in ratios ranging from 5:1 to 26:1 in the first year of life in the UK, USA, Australia and New Zealand.<sup>10</sup>
  - The ratio of biological fathers to 'stepfathers' (including mothers' non-cohabiting and short-term partners) where babies have been killed in England and Wales is 10:1. This increases to 15:1 when shaking is the cause of death.<sup>11</sup>
  - However, when factoring in the very small proportion of infants with a stepfather, the evidence suggests that stepfathers are associated with greater risk than birth fathers. The numbers are lower but the risks are greater.
  - The ratio of biological fathers to 'stepfathers' evened out or reversed for father-perpetrated homicide of older babies and pre-school children aged 1 to 5 years in England and Wales.<sup>12</sup>

7 Stöckl H, Dekel B, Morris-Gehring A et al (2017) Child homicide perpetrators worldwide: a systematic review. *BMJ Paediatrics Open*, 1:e000112.

8 Nobes G, Panagiotaki G & Russell Jonsson K (2019) Child homicides by stepfathers: A replication and reassessment of the British evidence. *Journal of Experimental Psychology*, 148(6):1091-1102.

9 Flynn S, Shaw J & Abel K (2013) Filicide: mental illness in those who kill their children. *PLoS One*, 8(4):e58981.

10 Nobes et al, 2019; Flynn et al, 2013; Brown T, Lyneham S, Bryant W et al (2019) *Filicide in Australia, 2000–2012: A national study*. Canberra: Australian Institute of Criminology & Monash University, Commonwealth of Australia; Mariano T, Oliver Chan H., Myers W et al (2014) Toward a more holistic understanding of filicide: a multidisciplinary analysis of 32 years of U.S. arrest data. *Forensic Science International*, 236:46-53; Martin J & Pritchard R (2010) *Learning from Tragedy: Homicide within Families in New Zealand – Working Paper*. Wellington, New Zealand: Centre for Social Research and Evaluation, Te Pokapu Rangahau Arotaki Hapori, Ministry of Social Development, Te Manatu Whakahiato Ora

11 Nobes et al, 2019

12 Nobes et al, 2019; Flynn et al, 2013.

- 4.2.** When the research scope was broadened to look at non-fatal NAI, a clear picture emerges. Fathers outnumbered mothers as perpetrators of identified abusive head trauma (AHT), and this is a consistent finding in international data with the fathers to mothers ratio ranging from 2:1 to 10:1.<sup>13</sup>
- 4.3.** There is also noteworthy data about the gender of babies abused. A consistent and well-evidenced finding from the literature review is that sons are more likely than daughters to be victims of father-perpetrated NAI. The one large international study that includes this data found that boys outnumbered girl victims 56% to 44%; even where mothers had been the identified perpetrator, boys were more likely to be victims than girls (53% boys compared to 47% girls).<sup>14</sup>
- 4.4.** In the cohort of cases for this review, 57% were boys and 43% were girls. In the much smaller sample of men we interviewed, boy victims outnumbered girls 2:1. At this stage, and without further research, it is not possible to draw any specific conclusions, but the difference is of note and warrants further inquiry.

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13 Brown et al, 2019; Wilson R (2018) *Child Maltreatment-Related Homicides: Examining Characteristics and Circumstances in the Context of Victim-Perpetrator Relationship* (Doctoral thesis). Georgia State University; Nuño M, Pelissier L, Varshneya K et al (2015) Outcomes and factors associated with infant abusive head trauma in the US. *Journal of Neurosurgery:Pediatrics*, 16(5):515-522; Scribano P, Makoroff K, Feldman K et al (2013) Association of perpetrator relationship to abusive head trauma clinical outcomes. *Child Abuse & Neglect*, 37(10):771-777; Sieswerda Hoogendoorn T, Bilo R, van Duurling L et al (2013) Abusive head trauma in young children in the Netherlands: Evidence for multiple incidents of abuse. *Acta Paediatrica*, 102(11):e497-e501.

14 Mariano et al, 2014

## 5. The data from our cohort

- 5.1.** We looked at 92 eligible cases that had come to the Panel; 23 of these were identified for a more in-depth review via the review's fieldwork. The data below relates to all 92 children.
- 5.2.** 81 were living with their birth father at the point of the abuse and only 11 with unrelated men:
- 45 were known only to universal services at the time of the abuse.
  - 24 were known to early help.
  - 12 were open to social care as children in need.
  - 11 were subject to child protection plans.
- 5.3.** In terms of ethnic background:
- 66 were identified as White British.
  - 6 were identified as Asian.
  - 3 were identified as Black and minority ethnic.
  - 3 were identified as a mixed ethnic background.
  - 14 cases information was missing.
- 5.4.** In terms of risk factors in the cases:
- 59 featured domestic abuse, either current or historical.
  - 32 featured mental health problems for the fathers.
  - 30 featured young parents.
  - 5 parents were care leavers.

- 5.5.** The fieldwork element of our review looked in detail at 23 of the initial 92 cases considered by the Panel to be the most relevant for this review.<sup>15</sup> These included:
- 4 cases where the fathers were the convicted perpetrators;
  - 4 cases where trials were on-going at time of the review (and in three of those both parents had been charged with murder);
  - 8 cases were still being investigated or were with the Crown Prosecution Service (CPS); and,
  - 7 cases where no charges were brought.
- 5.6.** Within the fieldwork cohort, four of the babies sadly died having suffered head injuries. Of these four babies, two died as a consequence of what appears to have been a one-off abusive incident and the other two showed evidence of historical injuries, indicating abuse suffered on more than one occasion. Of the 19 babies who survived, it was thought that five would be likely to suffer long-term impairment, that nine were likely to fully or nearly fully recover. For five babies, the prognosis was not known at the point of our review.
- 5.7.** In summary, the data shows that men are more likely to be perpetrators of physical abuse and harm to babies than women. It indicates that birth fathers are much more likely to be the perpetrator than other male figures. Importantly, whilst just over 50% of families had involvement with local authority children's services (either through early help services or children's social care), nearly 50% of the cases considered as part of this review were only ever known to universal services. This indicates that a significant proportion of these families and these men do not become visible to more specialist services until the abusive incident occurs.

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<sup>15</sup> The 23 cases were chosen to give a broad geographical spread and to include only children under 1 year old, where they had suffered non-accidental injury and where either there was a prosecution against the male or the indicators were that the male was responsible for the injuries.

## 6. Interviews with male perpetrators

### Background to the interviews

- 6.1. Securing interviews with the men involved was of crucial importance to this review because it brought a voice and a perspective rarely heard by safeguarding professionals and services. Almost all the interviews were conducted virtually, given the restrictions of the COVID-19 pandemic.
- 6.2. It was challenging to identify men who were willing to talk about their histories and role in abusing a child, but we were able to carry out eight interviews. Clearly this is not a large nor representative sample of men who have seriously harmed babies. The perspectives gained through these interviews nevertheless provide a valuable insight. It is important to bear in mind that this was a self-selecting sample of men who agreed to be interviewed and each man had his own reasons for consenting to do so.
- 6.3. Two of the men were mentally unwell (one was hearing voices) and this to some extent restricted the quality of the information obtained. However, other men engaged positively and fully; they appeared open and honest about what happened and seemed to accept full responsibility for their part in causing the injuries and for their apparent loss of control that had such terrible consequences for a baby.
- 6.4. Several of the men agreed to be interviewed because they said they were genuinely remorseful over what they had done and wanted to help to make a difference. They wanted to prevent other children from suffering the same fate as their own. In three instances, the men were grateful that they finally had a chance to give their perspective and to tell their story. Despite being involved in child protection proceedings, case reviews and lengthy criminal trials, these men felt that no one had ever asked them their views about what had happened, and that their experiences had never been heard.



You are the first person who has ever wanted to know what actually happened, what I went through. No one has ever asked me before....no one has ever bothered with me – you are the first person that has ever sat down and asked me my story”.

## What we learned from the interviews

- 6.5.** These men committed acts of extreme violence. The need to understand and respond to the roots of those violent acts sits at the heart of this review. The interviews revealed a damaging circularity in these men's lives: histories of multiple or significant difficulties in their childhoods, poor attachment histories, limited coping skills and problems with anger and a low frustration tolerance. These factors and experiences coalesced to create behaviour that was very dangerous to the safety and wellbeing of the babies for whom they were caring.
- 6.6.** Dr Tara Dickens' 2018 study of men who had perpetrated injuries or who had killed children in their care found that there were marked differences between men who were generally violent including towards their partners and those who were only known to have perpetrated severe physical abuse of a child.<sup>16</sup>
- “Convicted father perpetrators of severe physical abuse of their young child (without a conviction for associated partner violence) have lower self-esteem, anxious attachment styles and disengaged coping strategies; victim empathy, and moral justification of not using physical discipline, yet poorer knowledge of appropriate parenting strategies and age-appropriate child behaviour, compared to convicted male perpetrators of violence to other men – this suggests that anger, insecure attachment issues, misinterpretation of their child's behaviour, feelings of rejection by their child, and situation-specific issues override victim empathy at the time of the father's physical child abuse”.
- 6.7.** Yet the abuse does not appear to be solely 'parenting gone wrong'. The child harmers and the adult harmers in the Dickens study shared high prevalence of drug use, histories of impulsive behaviour, poor emotional and behavioural control, a low frustration threshold and heightened anger responses, which in several cases had been present since childhood.
- 6.8.** There are striking similarities between Dickens' evidence and that gained by interviews conducted as part of this review. Nearly all the men interviewed for this review had themselves experienced abuse and harm as children. They all described issues with their self-esteem. These are often described as 'adverse childhood experiences' (ACEs) and can manifest in adulthood as attachment disorders. The report from the clinical psychologist summarising the interviews with the men addresses both issues in more detail. The debate and continuing research around ACEs is acknowledged, including some of the limitations in the original concept. This particularly concerns an inherent determinism, a failure to acknowledge other adverse experiences beyond those listed in the original research and, most crucially perhaps, a failure to account for resilience and other factors that can mitigate adverse experiences in childhood. The notion that adverse experiences in childhood impact negatively on adults in later life is

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<sup>16</sup> Dickens, Tara (2018) An Exploration of the Psychological Characteristics of Men Who Cause Severe Physical Harm to Children Under the Age of Five. Doctor of Philosophy (PhD) thesis, University of Kent.. (KAR id:73278)

probably a matter of common agreement. It is within the capitalisation of those adverse experiences that opinions diverge. For clarity, this review refers to such experiences in the lower case.

- 6.9.** Insecure attachments can occur during childhood when there is abuse or trauma, and when the caregiver is seen and experienced as dangerous, harmful, unpredictable, rejecting, cold or inconsistent. As the child grows and develops, confused and troubled relationships with caregivers can result in problematic experiences that can shape and affect other relationships, especially those of a very personal or intimate nature. The consequence of insecure or problematic childhood attachments can thus be profound: leading some adults to have a poor sense of identity in relationships with others. Disturbed, chaotic and disorganised relationships can then feature prominently in the lives of these adults.
- 6.10.** However, it is important to point out that there were marked differences amongst the men we interviewed. One had never taken drugs, only drank socially and in moderation, and had never had any significant mental health history. He had no criminal record. There was nonetheless evidence of trauma in his childhood and he had a pattern of failed relationships in adult life. Another recalled a good home life with no problems. His parents were together through his childhood. He said: "I couldn't ask for better parents". While there had not been any obvious childhood abuse or trauma in his earlier life, the pressure of mounting debts and a destructive relationship with the mother of the child had pushed him beyond his already limited coping skills. His sense of shame about his situation seemed to prevent him from speaking out or seeking help.
- 6.11.** Seven of the men experienced childhoods which resulted in maladaptive coping strategies as a way of trying to manage their emotions or anger. Six turned to substance abuse to self-medicate for, sometimes seemingly low level, mental health problems, or to try to diminish the impact of traumatic thoughts and feelings. The more they used drugs or alcohol, the worse their impulsivity and volatility became. Their mental health then deteriorated even further and this in turn led to poor decision-making, even poorer emotional and behavioural regulation and significant relationship problems. This resulted ultimately in even greater anger, irritability and volatility.
- 6.12.** Only three of the men interviewed had previous convictions for violence, although some acts of violence had been undetected (for example, street fights that were never reported). A number of men had attended A&E with injuries from punching walls and some reported becoming increasingly angry and frustrated in the weeks and months leading up to the physical abuse of the baby.



**6.13.** Seven of the eight men had problems with anger and a low frustration threshold.

One said that he had:

“ Always had a problem with my anger – my earliest memory was at 13 – arguing with my brother. I threw a toy train at him, and it hit a glass door”.

Another man said:

“ I can go from being calm to very angry to very calm in a short space of time”.

**6.14.** Their behaviours may also have been exacerbated by other, more immediate, factors such as poor sleep. Many of the men with significant substance misuse problems were caught up in precisely these types of negative cycles. As a result, their lives were spiralling out of control. The only thing that stopped this from continuing was, tragically, the death or serious injury of a vulnerable infant.

**6.15.** To borrow from a theme identified by Dickens, this review found that ‘normal’ parenting activities (dealing with crying, babies being unwell, not sleeping) were being responded to within an abnormal context and behaviour, with tragic results.

**6.16.** There is some limited research evidence (set out in the literature review) about whether infant crying constitutes a significant trigger for father-perpetrated infant shaking and AHT<sup>17</sup>. Two of the men interviewed referred to a baby crying as having been a key trigger issue for them in losing control. This is exemplified in the account from one man interviewed for this study:

At 3 am he fed and changed (the baby), who continued to cry (“a piercing cry”). He was walking around the living room trying to soothe him, thought he'd settled, but then it started up again and he “sort of dropped him into the Moses basket”. He went into the kitchen and when he came back found the baby struggling to breathe. He immediately called for an ambulance.

**6.17.** Other seemingly routine parenting activities appeared to precipitate acts of violence by the men. This included one situation when the man was responding to the baby who was vomiting and, in another case, where the man described the baby seeming to have breathing difficulties. The following are two accounts from the interviews:

<sup>17</sup> Wilson, 2018; Adamsbaum et al, 2010; Zolotor A (2011) *Parenting of children under two: severe physical punishment and psychological aggression* (Doctoral thesis). University of North Carolina at Chapel Hill.



“ I was feeding him.... I could not get the wind up – I put him down and went up for a cigarette and when I went back in he was gasping for breath. I shook him and then shook him once more. If I were to shake him heavily, I would have broken his neck. I should not have done it. Previously he had held his breath and it scared me, and I shook him, and he went limp”.

Another said he picked his son up when...

“He spewed all over me”. He lost his temper momentarily and shook him. At first, he did not realise how serious it was until “I started winding him and I noticed that his hand went all stiff – I phoned the ambulance and started to do CPR – when I saw his hand go stiff, I knew that he was injured – I didn’t know at first what I had done”.

- 6.18.** The final trigger was not known in the other cases because the men concerned were either in denial or unable or unwilling to go into that much detail. Given that those interviewed were in prison and faced returning alone to their cells, such reluctance to talk in detail about what happened is perhaps understandable. One man interviewed continued to deny causing the injuries, claiming that what happened was an accident or a series of accidents, despite medical evidence showing this could not have been the case.
- 6.19.** These interviews make clear that, at least as far as this group of men are concerned, the injuries inflicted were abnormal and abusive responses to the normal and everyday behaviour of babies (crying, vomiting, poor sleeping). This occurred within the context of the man's life history together with more recent life stresses.
- 6.20.** The characteristics and behaviours this report identifies in men who go on to harm their babies undoubtedly occur in a much wider population. Many men have similar experiences and face similar issues but are able to care for their children well. The review did not find a “single identifier” that would assist practitioners in identifying potential or likely perpetrators. However, this review has come to two key conclusions. Firstly, it is in the combination of factors described here that risk occurs and secondly, the fact that too many men are not well engaged by services means that those risks go unidentified.

## 7. Impact of domestic abuse, substance misuse and adult mental health issues

### Domestic abuse

- 7.1.** The literature review indicates that there is little evidence to link partner violence and couple relationship conflict as prevalent factors in recent father-perpetrated abusive head trauma deaths.<sup>18</sup> However, Pennell and others found in an American study that when participants in their sample had committed violence, they were also likely to have perpetrated child maltreatment.<sup>19</sup> Evidence is nonetheless weaker than might be expected – though this may reflect the lack of research as much as a definitive comment on the relationship between domestic abuse and the physical abuse of younger age children.
- 7.2.** In another study, Temrin, Buchmayer and Enquist<sup>20</sup> (2000) explored motivations for the crime and found that often the killing of a child constituted a form of revenge or was motivated by jealousy. Cavanagh, Dobash and Dobash<sup>21</sup> (2006) also found evidence of jealousy and resentment as motivators in their review, both towards the child victim and towards an intimate partner, displaced on to the child. This raises a question as to whether factors such as jealousy could be a contributory factor behind the pattern of there being more male than female child abuse victims. In the absence of more research this can only be speculation.
- 7.3.** It is well documented that domestic abuse features in a high proportion of child protection work. Referrals from the police relating to domestic abuse tend to be the single most frequently presented issue in multi-agency safeguarding hubs (MASHs). It has been estimated that 60-65% of children on child protection plans will have had some experience of domestic abuse in their lives. This includes the damaging emotional impact on children of living in a household where violence

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18 Wilson, 2018; Dobash R & Dobash R (2012) Who Died? The Murder of Collaterals Related to Intimate Partner Conflict. *Violence Against Women*, 18(6):662-671; Makhoul F & Rambaud C (2014) Child homicide and neglect in France: 1991–2008. *Child Abuse & Neglect*, 38(1):37-41; Tiyyagura G, Christian C, Berger R et al (2018) Occult abusive injuries in children brought for care after intimate partner violence: An exploratory study. *Child Abuse & Neglect* 79:136-143.

19 Pennell, J., Rikard, R. V., & Sanders-Rice, T. (2014). Family violence: Fathers assessing and managing their risk to children and women. *Children and Youth Services Review*, 47:36-45. <http://www.sciencedirect.com/science/article/pii/S0190740913003459> doi: <https://doi.org/10.1016/j.chilyouth.2013.11.004>

20 Hans Temrin, Susanne Buchmayer and Magnus Enquist, 2000, Step-parents and infanticide: new data contradict evolutionary predictions

21 Kate Cavanagh, R. Emerson Dobash, Russell P. Dobash and Ruth Lewis, 2006, 'Remedial Work': Men's Strategic Responses to Their Violence Against Intimate Female Partners

and control are present and where one parent (almost always the mother) is suffering at the hands of the other.

- 7.4.** Despite the lack of evidence from research, it is a reasonable hypothesis that there may be a link between the commission of domestic abuse (against an adult) and real or potential abuse to children. This may feel intuitively the case for many practitioners. 64% of the 92 eligible cases considered in this review had evidence of either current or historical domestic abuse. Evidence indicates that abuse, or threats of abuse to children, can be used as an additional threat to mothers by male perpetrators of domestic abuse. The roots of domestic abuse (including differential power relationships, the felt need to exert control and the default to conflict resolution via violence) would seem to have a relevance and application to the role and behaviour of parents as much as in partner relationships.
- 7.5.** Four of the men we interviewed had admitted to being perpetrators of domestic abuse, another man was both a perpetrator and a victim and another had been a victim of such abuse. One had several previous convictions, including for violence. This man had been assessed by Probation Services as a medium risk to women and children in 2016 and had been requested to attend a domestic abuse programme through probation as a condition of his community-based sentence. He was sentenced twice with these conditions within a 3 year period, but for various reasons, he never attended a single session.

## **Mental health problems**

- 7.6.** The literature review found mixed small-scale evidence on the prevalence of fathers' mental health problems and alcohol and drug problems among AHT cases and no quantitative evidence about mental health problems, drug use or alcohol use as risk factors for father-perpetrated deaths (those not limited to AHT deaths).<sup>22</sup>
- 7.7.** In the review's fieldwork, many of the men were found to have had some degree of mental ill health. They may not have been diagnosed nor met a medical definition of mental illness but they nevertheless had histories of diagnosed attention deficit hyperactivity disorder (ADHD), anger management issues, anxiety and depression.
- 7.8.** Seven of the eight men we interviewed demonstrated low self-esteem. One was hearing voices and had anxiety and depression; another suffered from psychosis (voices, delusions, paranoia); two had depression and anxiety and four had post traumatic stress disorder (PTSD) or trauma related issues. One man had no obvious mental health problems but did have significant anger problems and extremely low self-esteem.

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22 Sieswerda-Hoogendoorn, 2013; Wilson, 2018; Dickens, 2018

- 7.9.** In the cases reviewed during the fieldwork, very few of the fathers were engaged formally with adult mental health services. GPs were therefore often the only agency that had information about the father's mental health.

## Substance misuse

- 7.10.** It is possible that some of the mental health difficulties experienced by men, as described in case reviews, are rooted in substance misuse. High levels of anxiety, depression and restlessness caused by a lack of sleep can be attributed to substance misuse. It is also possible that weak service engagement with men generally means that details about their levels of misuse are simply not being asked about or captured.
- 7.11.** Some men interviewed spoke powerfully about the impact of drink and (mostly) drug use on them and their lives. Some described many years of routine cannabis use; with some having smoked cannabis since childhood. In one instance, a man had started smoking before the age of 10. The use of modern cannabis in the form of 'skunk' can be very toxic, can have a very negative impact on emotional and psychological well-being and can also induce psychosis.
- 7.12.** In another case, none of the practitioners working with the family had identified that in the months leading up to the fatal NAI, the parents' cannabis habit was costing hundreds of pounds a week and this had, in turn, led to significant debt. By the time the child was injured and subsequently died, the conditions at the family home had become extremely poor. Police had visited the house twice because of neighbour complaints about the smell of cannabis, but this information was never shared with other agencies.

When at school, the individual met two boys who were smokers and together they smoked "every day, all the time". He confirmed that he continued to do so right up to the NAI incident in 2016: "Every day. If it's there, I was smoking it, there was no question". He started smoking cannabis as soon as he got up in the morning.

"For a time, I did illegal stuff and had a job so it would depend on the amount of money I had.... I don't know, £300/£400 [a week]".

He was asked how much he had been smoking leading up to the NAI incident:

"I don't know, ridiculous amounts. Obviously then I was drinking, I was doing cocaine. I was selling weed then, so obviously I had quite an amount of it. I used to get it cheap, so I don't know. You know the weights; I could smoke a quarter [of an ounce] in a day".

One man interviewed had been referred to drug misuse services but only attended once and did not engage with them. This information was not shared with his GP and the GP never checked but instead accepted the father's account. It was assumed that he was addressing his substance misuse as he claimed but this was far from the case.

- 7.13.** Domestic abuse, mental ill health and substance misuse were significant factors in the cases reviewed for this study. However, they do not have a direct causal relationship, so it is vital that practitioners and services better understand these potential connections. They need to explore them in-depth with parents, both mothers and fathers, to better understand and appraise how they manifest in particular situations and, crucially, how possible risks to babies can be mitigated and addressed.

## 8. The impact of contextual factors

### Young parents and care leavers

- 8.1. Nearly 40% of the cases in the fieldwork cohort involved very young parents. Becoming a parent at a very young age is challenging enough. When that is compounded by experiences of having been poorly parented, of living in poverty and poor housing, and then further aggravated by substance misuse or mental health issues, those challenges can become even tougher. They can be further exacerbated by social isolation and lack of access to a supportive extended family network that can offer help and advice as needed.
- 8.2. These challenges can become further exaggerated for those who have spent some or all of their childhood in the care system. The fieldwork indicated that other professionals poorly understand the role of the personal advisor in children's social care. Personal advisors play an important role in supporting care leavers and their ability to form helpful relationships was well evidenced. There was also evidence that assumptions were often made about their role in identifying the potential risk to babies with a tendency for other professionals to attribute a greater degree of responsibility for this to personal advisors than should be the case.
- 8.3. Later we set out some challenges for leaders and practitioners in terms of how there needs to be improved input to care leavers (both young men and young women) as prospective parents.

### Race, culture and poverty

- 8.4. Of the babies studied in our fieldwork, 18 were identified as White British; five were identified as Black, Asian, Black and minority ethnic or people with a mixed ethnic background. The impact of ethnicity and culture on parenting was not overtly considered or evidenced in the learning reviews that had been conducted locally. Of the wider sample of 92 cases, 14 had no reference to ethnicity or cultural background at all.
- 8.5. One case within the cohort prompted discussion about the ability of universal and safeguarding systems to engage with, or challenge, young Black men when the workforce is predominantly composed of White, middle class women. It remains a general fact that most agencies working with children and families, namely in midwifery, health visiting and social care, are largely staffed, especially in frontline roles, by women. There are challenges therefore for them, and their managers, to consider how they can better enable good engagement with men of all backgrounds, including those from Black and ethnic minority communities.

- 8.6.** An aspect of practice where there was a more explicit consideration of ethnicity was in the use of interpreters. In some areas interpreting services might not be easily available and practitioners expressed concern about the impact on assessments where family members were used to interpret.
- 8.7.** The task is not simply to record ethnicity and cultural backgrounds of families. Practitioners need greater confidence and competence in acknowledging and exploring how ethnicity, race, racism and culture affect parenting. These issues must be mainstreamed in practice thinking and discourse, and that requires an enhanced appreciation of the fact of racial and other social inequalities alongside a better understanding of approaches to parenting and family life in different cultures. This entails confidence in exploring these issues in person with different individuals and families so as to understand how they make sense of them. This expectation is not simply one that applies to working with families from Black and minority ethnic backgrounds; practitioners should consistently seek to understand every individual within the context of their own histories, backgrounds and culture.
- 8.8.** The review found that the impact of poverty and deprivation was poorly or rarely examined either in practice or subsequently in local case reviews. The greater prevalence of poverty and deprivation within Black and minority ethnic communities was not explored at all. Again this is not a new issue and was described in the [Department for Education's \(DfE\) triennial review of SCRs in 2019](#).
- “One issue that came through more commonly in these reviews, however, was the impact of poverty on families' lives. Poverty can have a profound and a long-term negative impact on children's lives, but recognition of poverty and its impact is often missing from or only obliquely referred to in reviews”.
- 8.9.** There is little sense that this has changed. The impact of poverty as a family stressor and therefore as a risk factor needs better attention than it is currently getting, despite there being clear links with, for example, substance misuse. The next section provides some guidance on how these issues could be better addressed in practice.



## 9. Information sharing and information seeking

- 9.1.** Information sharing difficulties, both perceived and real, lie at the heart of many safeguarding practice challenges. Many of the local case reviews seen by the Panel detail failures in sharing relevant information at the relevant time to relevant agencies. It is no surprise therefore that this study identified lack of information sharing as a key factor that prevented practitioners from seeing and responding in a timely way to risk to babies.
- 9.2.** The review identified three particularly prevalent issues. Firstly, there is a lack of patient record integration across parts of the health service. This is most noticeable in communication between midwives, health visitors and GPs. Research indicates that paternal attendance at pregnancy scans and at births is very high (over 90%) so men are generally seen by midwives and others. Despite this, some of the risk factors identified earlier may only be known to GPs and they require the consent of the father to share information with others. The various IT systems used by midwives, hospitals, health visitors and GPs do not always link or align. This has become a more acute issue since health visitors and midwives are no longer as aligned to GP practices as they previously had been. 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 and connected way.
- 9.3.** Secondly, the impact of GDPR other than under Section 47 of the [Children Act 1989](#) (child protection investigations) has been seen by many to have made information sharing less effective; it has certainly made it more complex. It was described in the fieldwork as a major barrier to safeguarding children, limiting professionals' ability to use pre-birth protocols and procedures to trigger assessments. There is something of a 'catch 22' in this; decisions about whether the threshold of Section 47 has been reached, or even that there is reasonable cause to suspect it might be, can only be taken if all relevant information is known, but the information can only be shared once the threshold has been reached.
- 9.4.** Thirdly, there was evidence of inconsistency in front door responses. For example, information from another local authority requested by one MASH was not provided due to father's refusal to consent despite the child having been subject to care proceedings. There was evidence in another case that had police checks been carried out in the MASH then these might have provided information on previous domestic abuse allegations against both parents. Discussions with practitioners indicated that they felt that thresholds about when to share information and when to refer cases into MASH remain unclear.



- 9.5.** Notwithstanding these problems, the review did identify an area of different and emerging good practice. The Sharing Information Regarding Safeguarding (SIRS) project developed by health partners in Northumberland ensures that:
- The mother and her partner are both invited to the booking appointment. At this point they are informed by letter that information will be sought from both parents' GPs, whether they are at the same GP practice or not. This is repeated at appointment.
  - A secure email is sent to the father's GP. Prompts are given about relevant information e.g. history of violence, anger, significant mental health issues or learning disability, substance misuse.
  - An administration team captures safeguarding codes and sends a pro-forma via secure email to the midwife within two weeks.
- 9.6.** Inevitably it is difficult to evidence that this approach has resulted in the avoidance of non-accidental injury, but the area was able to say that the project had helped, for example, to identify perpetrators of domestic abuse and situations where mental health issues impacted on someone's parenting ability. The result was that there was a wider body of knowledge about individuals and families available to the agencies involved. The project also acted as a useful counterbalance to parents who did not provide factual information regarding their past histories.
- 9.7.** A connected but separate issue relates to the failure to seek information proactively in order to piece together a more complete picture of a family and of the potential risks to children. This is best illustrated by a case example from one of the interviews carried out with the men. It is a case that tragically ended with the death of the baby.

In 2013, it was identified that the father was a '*potential risk to others when under the influence of drugs and this is having a major impact on his current presentation and behaviour*'. He had a long history of cannabis abuse, a long-standing problem with managing his anger and being short-tempered. Evidence available in 2018 was that he was having aggressive and at times violent outbursts. He was mentally unwell: he had been hearing voices telling him to harm others, he had chronic sleep disturbance and continued to smoke cannabis. His compliance with any prescribed medication was poor and his engagement with mental health services very erratic. The information about his risk was there and well documented in his medical records and yet none of this was communicated with children's services when he became a prospective and then new father.

The mother of his child had been well known to children's social care for over 10 years. She had significant known vulnerabilities including a recent history of domestic abuse, mental health problems and a possible learning disability. Despite her history and various concerns about her parenting, when she became pregnant by the father, none of this information was gathered.

During ante-natal appointments issues were identified in relation to father's mental health and concerns were raised, yet this was not followed up. GP records show that he was discussed more than once at the GP safeguarding meeting, but this did not result in a referral to social care or any other agency.

- 9.8.** The case illustrated the imperative of professionals actively seeking information from other agencies to secure a more rounded and fuller picture of what life is like for a family and particularly for the children living within it. It is important to grasp what gets in the way of professionals doing this consistently well.
- 9.9.** During the course of two very productive roundtable events with representatives from professional health bodies and the associated Royal Colleges, it was stated that the necessary legislation was in place to enable such information sharing. In particular, the General Medical Council (GMC) guidance was deemed clear and unequivocal. Organisational culture and leadership were identified as key causes of the variation in how well practitioners share information as opposed to the lack of appropriate guidance.
- 9.10.** A cross-government piece of work on information sharing was commissioned in 2019, with user research commissioned from NHS digital. This aims to explore leadership, cultural and behavioural issues, as well as technical problems. Additionally, the Department for Education is in the process of reviewing the non-statutory guidance on information sharing that sits alongside Working

Together 2018. The Panel is contributing to this work. Its purpose is to produce clear guidance, supported by a clear communication strategy, to empower safeguarding practitioners to share relevant information in order to improve risk assessment and decision making for the most vulnerable children in our community.

- 9.11.** Work on this review has also been an opportunity for the Panel to further explore an issue that it first raised with the Home Office in 2019. This is about the need to implement some form of national tracking system for men convicted of physical harm to children. The Panel recognises that this involves consideration of a particularly complex set of issues but it is one that requires detailed exploration with relevant national bodies, including the police, to test practicalities and perceived benefits. The Panel will continue to work on this issue with a view to further reporting.
- 9.12.** Very considerable risks to children result when there are problems in sharing information about the needs and risks of fathers. Failures in information sharing and information seeking can have very harmful consequences when the entirety of the safeguarding picture is not visible across the multi-agency network.

# Analysis and implications

## 10. Analysis

- 10.1.** This section provides analysis of the review's findings. There is consideration of what the review's findings might mean for universal and specialist services for children and families and for those which are adult-facing.
- 10.2.** We have described the numerous and complex roots of the abuse and harm that babies in this review have suffered. These include the histories and psychologies of the men involved, such as poor emotional regulation and high frustration levels. There is also the presence of substance misuse and mental health problems, the co-existence of domestic abuse, and the impact of pressures of race, culture, deprivation, all of which exist within a society with powerful gendered roles about parenting.
- 10.3.** Given that complexity, simple solutions are not enough. The challenge for service leaders is to get to grips with the nature of these issues and think through how they can address them holistically. What is required is a significant shift nationally and locally in how services 'see' and respond to fathers of babies. This is a prerequisite to securing improvements in the effectiveness of safeguarding practice for babies.

# 11. Universal provision

**“ The man is not on my caseload”.**

A quote from a health visitor during this review.

**“ Every time the health visitor or social worker visited, a pretty picture was painted by [mother] and I stayed silent. Imagine me sitting there thinking ‘what a crock of shit’. I often thought about following the professional out and telling them that everything is false. As soon as she left the house it was tantrums and chaos again. The people coming in our home never really knew how horrible the household was”.**

A quote from one of the men interviewed.

- 11.1.** Of the 92 cases in our original cohort, 45 (49%) were known only to universal service provision and a further 24 (26%) were known only to early help services. If our sample is in anyway representative, it means that a large number of these families and these men never become visible to more specialist services. Universal and early intervention (sometimes known as early help) services need to be better aligned to engage with and be alert to potential risk factors fathers might present.
- 11.2.** It was a matter of common agreement with all the people we spoke to, borne out by our literature review, that services covering the antenatal and early months of life period in England remain resolutely women-facing. They are seen and experienced as services for women run, primarily, by women. There is no suggestion here that this should not be the case – services aimed at pregnancy, birth and the early days and weeks of life must be, above all else, relevant to the needs of women. That is a given.
- 11.3.** However, what we would argue is that this should not be at the expense of the involvement of men, as the inclusion of one parent should not result in the exclusion of the other. Dr Carmen Clayton (Leeds Trinity University) has undertaken research on the experiences of young fathers, defined as men who are under 25 at the time of the first pregnancy or birth. The findings emphasise the strong desire to be included and to receive information from health professionals.<sup>23</sup>
- 11.4.** Public Health England (PHE) convened a ‘Fathers Summit’ in May 2021 at which some important and relevant data was presented. This included Sean Mackay (Liverpool John Moores University) describing research that sets out the long-term benefits for both the child and the mother of good paternal involvement. His

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23 New Pathways for Young Fathers report: [New-Pathways-Young-Fathers-Report-NOVEMBER-FINAL-2.pdf](#) (daddilife.com)

unpublished work 'Silently Panicking' looks at online peer support for fathers from the antenatal period to early years.

- 11.5.** Other research found that fathers with depression in the postnatal period were 21 times more likely to present suicide risk than those who did not suffer from any mood disorder.<sup>24</sup>
- 11.6.** Better Births, the report of the National Maternity Review was published in 2016 and included in its vision the need 'for maternity services across England to become safer, more personalised, kinder, professional and more family friendly'. The report states:
- "Some fathers told us that they had felt excluded, that their role had not been recognised and so opportunities were missed to support the family and to have as positive an experience as possible. Some women told us that they relied on their partner to support them in pregnancy and with the care of the baby and the NHS needed to recognise this and help their partners to help them".
- 11.7.** However, there is little in the body of the report, or in those early adopter sites that tested the model of care outlined in the report, that is directed at the increased engagement of fathers – the report quotes the importance of focussing on the needs of women, babies and their *families* (our emphasis) which whilst clearly including fathers does not specify them. It is this lack of specificity and lack of identification of the need to directly involve fathers that we are highlighting in this review.
- 11.8.** This lack of engagement was reflected in our fieldwork. The strong evidence from that cohort of cases was that antenatal services are insufficiently flexible - they are rarely provided out of hours or at weekends and not offered in a way intending to maximise fathers' participation and involvement. As a result, fathers or those in the father role are not provided with the information or education provided to mothers on the needs and impact of infants within families. This means that they may not always develop an awareness of the impact of crying and how to feed and handle babies safely. Fathers not being at appointments does not generate the same level of response that would apply to mothers.
- 11.9.** In addition, the fieldwork identified that many health professionals never explored with the mothers who the prospective father was and their view of their involvement in the baby's life. Unless they were living in the household, questions were often just not asked. Increasingly women reported meeting their partners online and so themselves knew little about them or their history. There may also be an increasing reluctance for women to identify men as present if, for example, it affects their benefits to say they are not a single household.
- 11.10.** These are not new issues. In 2005, Dr Lisa Bunting, found that when health visitors estimated the needs of both teenage mothers and their partners as high, they

would generally expect the young mothers' parenting capacity to be average to good, and the young fathers' parenting capacity to be poor.<sup>25</sup> They were likely to impute any decreases in couple/ paternal contact to negative characteristics in the fathers. These assumptions were made despite health visitors knowing very little about the young fathers.

- 11.11.** In 2015, Humphries and Nolan found that '...there is little evidence that the importance of engaging fathers is reflected in health visitor training or that primary care services are wholly embracing father-inclusive practice'.<sup>26</sup>
- 11.12.** In 2003, the Sure Start evaluation programme 'Fathers in Sure Start' concluded:
- "Although the majority of staff stated that greater father involvement in Sure Start was desirable, interview data suggest that involving fathers may be peripheral to the work of some Sure Start programmes. One of the clearest findings to emerge from interviews with fathers in this study was the importance they placed on fatherhood. All of the fathers interviewed said that being a father was important to them and that their children were a vital part of their lives. The interview data suggest that fathers in Sure Start local programme areas may be committed to being fathers, play a key role in the lives of their children, yet tend not to engage with Sure Start programmes".<sup>27</sup>
- 11.13.** A number of barriers to fathers' involvement in Sure Start were identified, including predominantly female environments or lack of male presence, Sure Start opening hours and fathers' employment hours and traditional, gendered attitudes towards childcare and gender roles. This evaluation remains a valuable insight both for future developments and for existing provision in ensuring their safeguarding work is well-focused on the key area of risk that might be presented by fathers.
- 11.14.** This review is taking place after a number of years of austerity in the public sector and we recognise that this has inevitably had significant impact on the services in question. The Local Government Association (LGA) has estimated that the number of health visitors dropped from 10,000 in 2015 to 8,000 in 2019.<sup>28</sup> Public health budgets reduced by over £500m during this period.<sup>29</sup> This represents a substantial reduction in the capacity available to support parents, both mothers and fathers, with babies and young children. Concern was raised by local areas during our fieldwork about how realistic it is to expect midwives and health visitors to deliver their core health care duties at the same time as developing their capacity to assess the needs and risks of fathers.

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25 Teenage parenting Professional and personal perspectives – CORE

26 Humphries and Nolan (2015) *Evaluation of a brief intervention to assist health visitors and community practitioners to engage with fathers as part of the healthy child initiative*, Primary Health Care Research and Development, Cambridge Core

27 Sure Start evaluation programme 'Fathers in Sure Start' by The National Evaluation of Sure Start (NESS) Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London 2003

28 Health visitors 'in decline' *First* magazine for councillors [www.lgafirst.co.uk](http://www.lgafirst.co.uk)

29 <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health>



- 11.15.** The review has not identified any specific services for men that were previously available but are not now delivered. There is nonetheless a wider public sector challenge around the resourcing of early intervention and preventative services. The fact that many areas have seen, for example, a significant decrease in the number of children's centres highlights this and is important context for this review.
- 11.16.** In October 2015 the responsibility for commissioning public health services for children aged 0-5years passed from NHS to local authorities. We heard conflicting reports about the impact of this change. Some felt that it had resulted in a lessening of focus on core health visiting duties, while others could reference the benefits of greater integration with other relevant local authority services. Other people were of the view that health visiting commissioning when done by the NHS was not necessarily successful either. The need that stood out, regardless of who led the commissioning, was for effective leadership to strategically and operationally connect health visiting to other local services.
- 11.17.** In the roundtables, there was also discussion about the impact of local decommissioning of Family Nurse Partnership (FNP) services. Such arrangements were only evident in four of the 19 areas reviewed. A research report published by the National Institute for Health Research in February 2021<sup>30</sup> found that, whilst there was evidence of FNP improving levels of school readiness, the programme 'did not reduce the number of children who were referred to social services, were registered as in need of additional support, were given a child protection plan or entered care'. However, our review evidence shows that the loss of FNP programmes locally was felt to be significant because of their ability to support young families and to identify risks (young families constituted 40% of the fieldwork cohort).
- 11.18.** We did find some examples where local services were addressing the need to better engage men and fathers. Both Cornwall and West Sussex have implemented The DadPad, an interactive online site to provide information and advice for new fathers. This is now available in other parts of the country. Cornwall is also home to the WILD Young Parents Project, a voluntary organisation which offers one-to-ones and group work support to young fathers. In Manchester, Dad Matters, another voluntary body, offers support and outreach to new fathers. In Bristol, MIND provides support to fathers who are either anxious or isolated themselves, or whose partners are experiencing antenatal or postnatal depression. These services do not appear to be widespread nor are they seen as a core part of universal health provision.
- 11.19.** The key message to universal services is this: in a society which expects women to take a disproportionate responsibility for children, opportunities to increase both the involvement of and expectations on men to assume more responsibility

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30 Robling M, Lugg-Widger F, Cannings-John R, Sanders J, Angel L, Channon S, et al. The Family Nurse Partnership to reduce maltreatment and improve child health and development in young children: the BB:2-6 routine data-linkage follow-up to earlier RCT. *Public Health Res* 2021;9(2).

as fathers are missed. Further, in relationships and families where fathers are, for whatever reason, not wanting or able to engage in antenatal and postnatal services, then those services can enable them to avoid their responsibilities. It means that the potential to use impending fatherhood as a 'reachable moment' may be lost. It means too that there is reduced ability to identify those men whose vulnerabilities might require further specialist input and it is less likely that the risks they may present are identified and acted upon. In the next section, we explore how this theme is mirrored and evident in more specialist services.

## 12. Specialist services

“ Every time I spoke to my social worker, I felt like screaming, “I’m not invisible, I am right here, and I’m willing to love and care for my son” but I felt that no one was listening”.

A father speaking at a recent Family Rights Group Event - Our Families, Our Voices

- 12.1.** The involvement of men is no more evident in key statutory children's services, particularly children's social care, than it is in universal services. Men are only partially seen (if that) and insufficient regard is given to working effectively and creatively with them. This compounds the ability of some men to evade responsibility and scrutiny from professionals for the risks they present to their children.
- 12.2.** As with universal provision, this is not a new problem. In 2008, the (then) Department for Children, Schools and Families (DCSF) commissioned work to examine the extent to which DCSF and its partners' policies recognised and responded to fathers and to identify the barriers to their engagement.
- 12.3.** Published as 'A Review of How Fathers Can be Better Recognised and Supported Through DCSF Policy' one of its many findings was that:<sup>31</sup>
- Engagement with fathers in family services should be routine. However, very few local authorities or family services have begun to develop pro-actively father friendly policy or practice and, where this has occurred, it has tended to be sporadic and dependent on specific managers and staff taking a sustained interest in working with fathers.
- 12.4.** It is one of the recurrent themes of this review that engagement with fathers is characterised by shallow assessments and weak engagement – services do not know who they are nor the risks they present with nearly enough regularity. This finding is supported by research – fathers are invited to child protection conferences only 55% of the time<sup>32</sup>; known violent fathers are not contacted by social workers prior to meetings 38% of the time<sup>33</sup> and only 68% of completed assessments included contact with the father.<sup>34</sup>

31 A review of how fathers can be better supported through DCSF policy ([ioe.ac.uk](https://dera.ioe.ac.uk/8562/1/DCSF-RR040.pdf)) <https://dera.ioe.ac.uk/8562/1/DCSF-RR040.pdf>

32 Osborn, M, 2014, 'Working with fathers to safeguarding children', Child Abuse and Neglect, Volume 38, pp993-1001

33 Baynes & Holland, 2021, Social work with violent men: a child protection file study in an English local authority

34 Working with Risky Fathers"" Fathers Matter volume 3: Research findings on working with domestically abusive fathers and their involvement with children's social care services. Ed: Cathy Ashley 2011

## “Recurrent” fathers

- 12.5.** Recently published research on care proceedings (“Up Against It”) indicates a similar lack of engagement with fathers.<sup>35</sup> Significant growth in care proceedings in recent years has prompted questions about the extent to which some parents, particularly mothers, are featuring in those proceedings on more than one occasion. Commonly termed “recurrent care proceedings”, evidence suggests that at least 43,500 mothers between 2007 and 2014 were involved in these types of proceedings. A significant number of local authorities and third sector organisations in the UK now offer services to address recurrence, with notable examples being the ‘Pause’ programme in England and ‘Reflect’ in Wales, both of which have been financially supported by central government.
- 12.6.** However, it is estimated there are also up to 30,000 fathers who would also fall into the same definition of ‘recurrence’. In contrast to the response to mothers, very little is known about them and the circumstances and experiences of their involvement in repeat care proceedings and subsequent loss of their children.
- 12.7.** This research has, for the first time, explored this in some depth. It examined the circumstances of these men and included some interviews with them. The reviewers identified some of the factors that recurrent and non-recurrent fathers in care proceedings had in common - predominantly White British, English speaking, non-religious, never married, becoming a father at a younger age, and living in economic hardship. The study also identified those factors which differentiated them – these included being looked after as a child, experience of multiple childhood adversities, being unemployed, and not living with their youngest child.
- 12.8.** Their research found that 20% of cases appear with a missing father – and, they concluded, this implies the need to do more to both identify that group and to ensure the needs of the 80% are better met. The majority of recurrent fathers reappear before the court with the same partner (79%).
- 12.9.** As with our work, their findings are that these ‘recurrent fathers’ are a very vulnerable group who have experienced multiple disadvantages both in their childhoods and more recently. Whilst they may pose a risk, they are themselves also at risk and need to be seen and treated as such. “Up Against It” also reflects on the deep-seated societal nature of some of the findings. It concludes that efforts to address recurrence must necessarily involve engaging with longstanding debates about fatherhood, the gendered organisation of care and parenting and stereotypical thinking about fathers and mothers in public services. These themes all strike a chord with this review.

## Care leavers

- 12.10.** There is another key area of focus for the care system which relates to the needs of care leavers as parents. The Panel sees too many care leavers having difficulties as (often very young) parents and there is a national need for the care system to focus on preparing young people for parenthood in the same way as it is charged to prepare them for adulthood. Key performance indicators that relate to care leaving services tend to focus on the latter issue – measuring those in employment, education or training, or the quality of housing they are in – and not on mental and emotional well-being and on their readiness for parenthood.
- 12.11.** In one of the roundtables convened for this review, the issue of whether care leavers should automatically trigger a pre-birth assessment was considered. The debate was between their need for support on the one hand and a perceived stigmatisation on the other. The view of this report is that it should be a routine response for any care leaver who is to become a parent – and this must of course include both young men as well as young women. This is not to stigmatise them, if anything it is to do the opposite. It is to ensure that the system responds as good corporate parents and enables them to become the best parents they can be with the preparation and support they need, informed by a timely and comprehensive pre-birth assessment.
- 12.12.** In conclusion, we found that fathers are both absent and enabled to be absent across the range of service provision through child in need, child protection and children in care services. There is insufficient evidence that this absence is being routinely tackled within the system – and if men remain absent or invisible then the support they might need and the risks they might present cannot be routinely addressed. Through the course of this review we found little evidence of good or promising practice and our national call for evidence elicited no response. We believe that these are core problems requiring mainstream solutions and we have not found evidence to suggest that is happening.

## 13. Responding to domestic abuse, substance misuse and mental health issues

**13.1.** In the previous section, we described our findings relating to domestic abuse, mental ill-health and substance misuse in heightening the risks to babies of NAI. Here we analyse those findings further and set out the implications for safeguarding practice and policy.

### Responses to domestic abuse

- 13.2.** Midwives and health visitors ask mandatory 'routine enquiry' questions on domestic abuse to women. However, we found that there were questions about the effectiveness of this approach when there is limited capacity to develop trusting relationships with parents, when women frequently may not recognise their relationship as coercive or controlling and when there are added complexities such as men being present or when interpreters are used. Midwives and health visitors in our fieldwork were unable to provide very many examples of these questions being responded to positively or leading them to different service responses.
- 13.3.** Our fieldwork identified that Domestic Abuse Stalking and Harassment (DASH) assessments and other tools used by agencies to assess risk focus on risk to adults not children. The essential links between multi-agency risk assessment conferences (MARAC) and child protection systems need to be robust and include a link between safety plans for adults and child protection assessments and responses.
- 13.4.** It was suggested by a number of the fieldwork areas that some form of national system is required to track fathers who have previously had domestic abuse convictions and then move in with other partners and their children. There was evidence from those who were part of this review of repeat offenders who had not been recognised as presenting a risk despite past behaviours. It was also apparent from our fieldwork that Clare's Law<sup>36</sup> is not widely understood by practitioners or promoted sufficiently to support mothers in using the system and understanding potential risks to their children.
- 13.5.** We have looked at a number of programmes designed to address domestic abuse and in particular those which specifically address men as perpetrators. We looked at:

- Behaviour Change Independent Domestic Violence Advisers (IDVAs) – who work specifically with men as abusers and are currently operating in Devon and Wiltshire.
- Caring Dads – being delivered in Leeds and elsewhere, a groupwork programme developed in Canada and focussing on addressing male abusers to become better fathers, and by extension better partners. It works at the statutory end of childcare – children in need and child protection. This has been subject to a positive evaluation by NSPCC in 2016-17.
- For Baby's Sake – a charity that delivers a programme working with both parents at point of pregnancy and into the first weeks and months after birth, positively evaluated by Kings College, London.
- Safer and Together – in Hackney, Islington, Barking and Dagenham and Waltham Forest, developed in the USA and designed to reduce the impact of domestic abuse through working together with the abuser and their victim.

**13.6.** It is not the role of this review to evaluate or judge the merits of these various approaches. However, one characteristic that they all shared was that each of them had at their heart the need to engage and confront the man with his behaviour and the consequences of it to those around him, especially his children.

**13.7.** The Early Intervention Foundation (EIF) has summarised the available evaluations of these and other programmes.<sup>37</sup> One of their conclusions, and the one most pertinent to this review, is that 'there is no robust evidence to indicate that children benefit from their fathers participating in the programme'. They attribute this to 'the lack of robust study designs being implemented in evaluations and therefore changes observed cannot be attributed to the programme itself' although 'qualitative evaluations have tended to show perpetrators perceive such programmes as having a positive impact on child outcomes (for example, parental relationships and safety)'. This review supports their conclusion that 'far more robust evaluations, measures which collect child data directly and evaluations which put child outcomes at the forefront of their aims and objectives are required before we can fully ascertain whether perpetrator programmes causally drive positive outcomes in children'.

**13.8.** We are aware of course that the Domestic Abuse Act 2021 has now been passed into statute and there is to be a Perpetrators Strategy developed and published later in 2021. This offers a real possibility to develop a more coherent approach to violent and controlling men that combines both challenge and support, and addresses the risks they present to both adults and children.

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<sup>37</sup> 'Assessing the state of evidence regarding perpetrator programmes in instances of domestic abuse' Private Advice from EIF to the Panel Review of NAI in under 1-year olds



**13.9.** Although the co-existence of domestic abuse and risks to children appears to be well known in the safeguarding system, this review has highlighted some serious gaps in that understanding and in the response to it. Programmes aimed at perpetrators are not universally available and where they exist, the impact on the safety and wellbeing of children is insufficiently evaluated. The need to challenge men about their behaviour and the risk they pose to adults, which underpins domestic abuse perpetrator programmes, is not consistently replicated in challenging them as fathers. Equally, we found little evidence across the system that mothers were proactively supported to keep both themselves and their children safe, although it is clear they are expected to do so.

### **Mental health problems and substance misuse**

**13.10.** Unlike the range of extra familial risks faced predominantly by young people, when the threat often comes from other young people, it is a matter of fact that it is adults who represent the risk to children under 1 year old. Some of those adults either need or are in receipt of services in their own right. When they are in receipt of those services, whether because of mental health or substance misuse issues, there is evidence that there is often insufficient linkage between children's and adults' services, raising some important questions and challenges.

**13.11.** This is sometimes referred to in case reviews as a failure to 'think family' although it is not always clear what that term is taken to mean. For these purposes, we use it to describe the failure of the whole system to identify and meet the needs of a family in an integrated way, resulting in unhelpful and at times dangerous gaps appearing between children's services and those focused on adults. These issues create policy, practice and service design challenges for both adult services and the children's safeguarding system.

**13.12.** A range of practice orientated questions need to be posed. For example: to what extent are agencies who work with adults aware of, and alert to the fact that these adults are or might be parents? How can adult practitioners be more alert to the risks to children that may be becoming evident as a consequence of the work they are doing? To what extent is anxiety about information sharing getting in the way of alerting children's services to risks?

**13.13.** It appears that when there is evidence of clear and present danger to children then referrals are made. The concern is where the risks are less well defined. They might include, for example, knowledge about a man with a mental health problem, known to have anger management issues or poor emotional regulation, forming a new relationship where there are children in the household.

**13.14.** There are important questions for children's services too; these focus particularly on the often unexplored nature of drug usage. This review has identified the need to be much more alert to the risks of anger, frustration, poor impulse control especially when accompanied by high levels of drug use. References to an awareness of cannabis use – smelling it in the house for example – are



quite frequent in reviews and in some of the material we have explored and there is a sense that that usage is normalised by the system, taken for granted and not seen as a major risk factor demanding assessment. There is insufficient evidence that the level of usage is thoroughly examined or assessed, nor is the impact of the usage on parenting and levels of emotional well-being routinely understood. There is a need for children's practitioners to better understand the difference between use, misuse and addiction. Behaviour patterns associated with addiction seem poorly understood and indicate that much more needs to be done to support children's practitioners to understand and respond better to patterns of drug misuse, its impact on parenting and on the health and safety of babies.

- 13.15.** The second set of issues relates to that of service design and specifically service eligibility. Looking at adult services, there is a series of questions about those that are and are not in receipt of services and those who have or have not been defined as having care and support needs. [The Care Act 2014](#) states that within the duty to promote an individual's well-being, there is a specific inclusion of the duty to promote domestic, family and personal relationships. Furthermore, it goes on to say that a local authority must have regard to the need to protect people from abuse and neglect. We believe therefore that there is appropriate legislative encouragement to support the needs of parents more extensively than seems evident in this review.
- 13.16.** This has a specific resonance in adult mental health services. They are frequently delivered by health-based trusts and can have a very medicalised model of mental health. This can mean that some of the issues experienced by men in this review are not addressed. Thresholds and prioritisation of limited funds means that adults with some mental health needs (for example, personality disorder or depression or anger management and lack of impulse control) or less serious substance misuse issues will not receive a service. The ability to meet these needs through community-based interventions seemed to be lacking, at least in terms of evidence to this review. However, those are often the very factors that can present serious risks to children and often warrant statutory intervention – in other words, they trigger children's services priority responses.
- 13.17.** Put simply, adults who present a lower level of need to adult provision can present the highest level of need to children's services. These adults can therefore represent an enormous financial and service demand on the system as a whole, let alone create the havoc, harm and sometimes tragedy that affects some children.

## 14. A note on crying

- 14.1.** This review has described the potential impact of crying as a precipitating factor of non-accidental injury to small children. There is a need to support practitioners in all relevant services to understand these impacts so that they can work more effectively with families. One relevant programme is ICON<sup>38</sup> (Infant Crying is Normal; Comforting Methods can help; It's Ok to Walk Away; Never, Ever Shake a Baby). This has been designed to improve parental reaction to crying and specifically to reduce incidents of abusive head trauma. Key messages are delivered at five key touch points:
- At the hospital before discharge.
  - By the community midwife in the baby's first 10 days.
  - By the health visitor in the first 14 days.
  - By the health visiting again at three weeks.
  - By the GP at the six-to-eight-week postnatal check.
- 14.2.** ICON is now operational in 35 different local authority and health areas across the country. Its terms of reference specifically include the need "to make a concerted effort to engage men at each touch point and through any other means". However, there is an acknowledgement that accessing male partners remains an issue in more than 60% of their areas. The programme's social media output is targeted at men. A video that was posted on Facebook and Twitter called 'Dad's cry' had over 10,000 views and contributed to a 300% increase in male engagement.
- 14.3.** There has been some positive early evaluation by Hampshire CCG where ICON originated. It is understood that a broader nationwide evaluation will be conducted. The exponential take-up of this programme across the country is noted and local safeguarding partnerships and commissioners are urged to make sure that it has a specific focus on the engagement of, and impact on fathers.

# What this means for practice

## 15. Towards better practice

**“ Father was indeed very volatile and aggressive, and there have been subsequent police reports in respect of violence in his intimate and family relationships, but my practice experience of father was that he was a very scared young man who struggled to regulate himself. When he was provided with an interaction that aimed to speak to the fear that was hidden by his volatility, he would respond in a very different way – often becoming upset and being able to speak about his worries”.**

A practitioner in our fieldwork discussion.

- 15.1.** It is true that the skills and knowledge held by safeguarding professionals who work with children and families can and should be used when working with men. Approaches to engagement, to interviewing and to listening should be the same for both women and men. Exploring their histories, where they draw their support from, how they see their futures – again, this is common ground for those working in the field and applies to both men and women. The evidence from this review suggests that there is insufficient evidence that practice with men has these characteristics.
- 15.2.** As a consequence, extra steps are needed if we are to going be more effective in working with fathers and male partners – especially with those where other evidence would suggest they might present a risk to their children.
- 15.3.** Finding, engaging, assessing and working with these men is often not easy and we are not suggesting otherwise. Some of them very actively do not want to be found. Some have deep seated feelings about many state agencies, some will lie, threaten or act aggressively to staff. Some will simply absent themselves from working with professionals and from any sense of responsibility for their children. Some of the men we interviewed in prison continued to deny or minimise the damage they had caused to children, and it was clear in some instances they were still not being honest with us or themselves.
- 15.4.** There are approaches and practice guidance available that focus more specifically on working with men, some of which are referenced below.<sup>39</sup> Much of this work has been rooted in an exploration of men involved in formal statutory

<sup>39</sup> Working effectively with men in families - including fathers in children's social care. Produced in July 2017 by Professor Brid Featherstone and published by Research in Practice summarises other research and work in this area. It describes differential approaches as they apply to early help and statutory intervention.

'Counting Fathers In': Men's experiences of the child protection system. Norwich. Developed by Marion Brandon and colleagues at the Centre for Research on Children and Families, University of East Anglia looks specifically at men's experience of the child protection system.

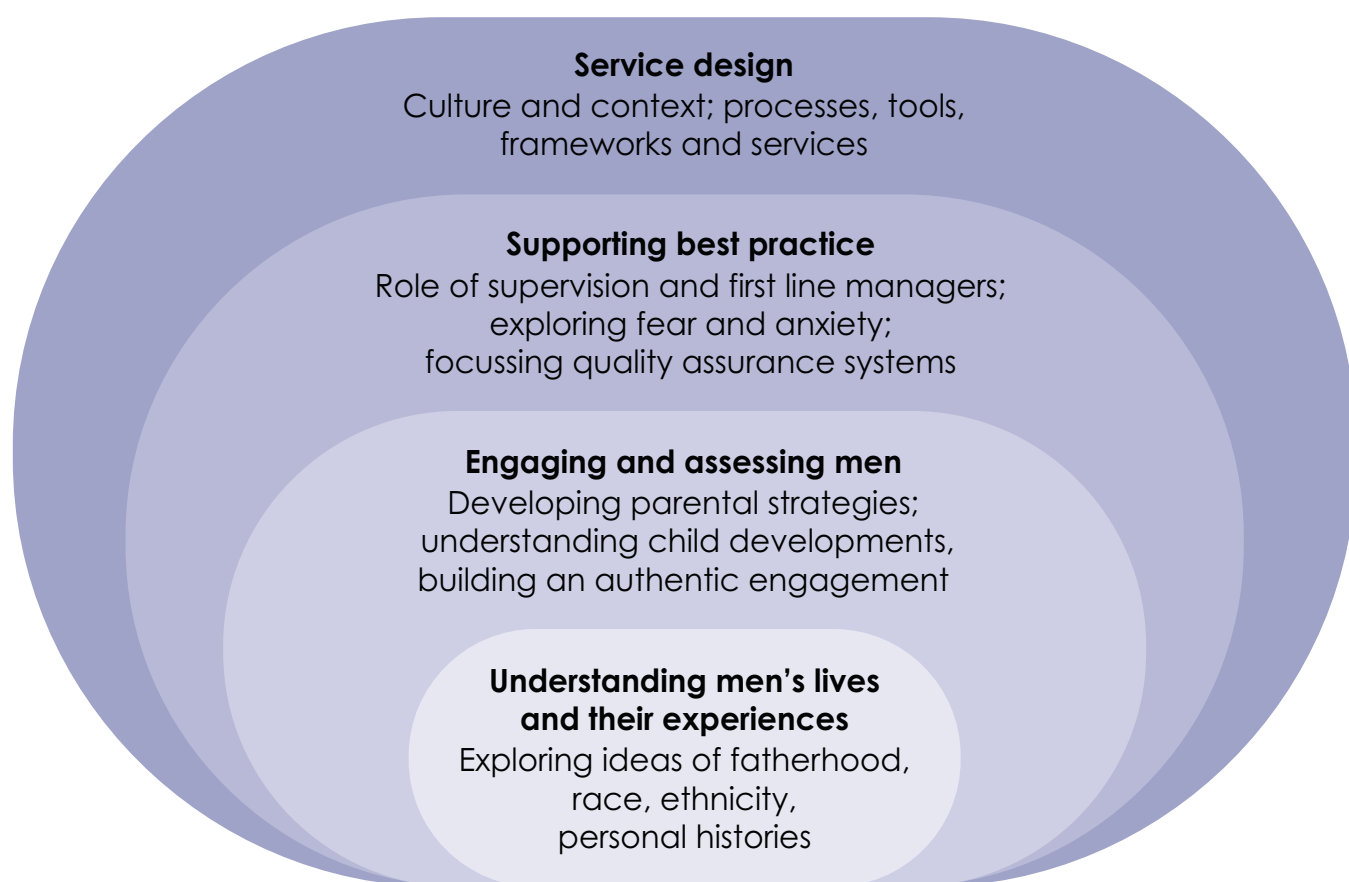
'Developing an approach to include fathers in children's social care' – Dr Gavin Swann

'Working with fathers in child protection: lessons from research', Jon Symonds, Community Care Inform, July 2014 updated Feb 2018.

'Good practice with fathers in children and family services' – Gary Clapton, University of Edinburgh June 2017

processes and is therefore aimed primarily at social workers. However, there are some general conclusions that are of importance to all front-line staff engaged with families, from midwives to health visitors to general practitioners and social workers. This report builds on that guidance to include the findings from our research and sets out a four tier model to help improve the engagement and assessment of fathers.

These four tiers are interlinked and the challenge to the safeguarding system is to see and implement them systematically to make the kind of step change necessary in working with fathers and protecting babies.



## 16. Understanding men's lives and their experiences

- 16.1.** The first task is to understand the context and background within which a particular man has lived and continues to live. Ideas about 'manliness' and fatherhood are deep rooted and vary across cultures, ethnicities and class. Fathers are not a homogenous group and should not be approached as such. Those who are non-resident, those who are from an ethnic minority or those from White working-class backgrounds are all likely to face particular and different circumstances and pressures. These need to be understood and assessed as they apply for that individual and not be based on assumption or stereotypes. Some will have had very damaging childhoods, others less so. All of them will come with an experience of their own fathers and of being parented and a sense of what being a father is and should be.

### Engaging and assessing men

- 16.2.** Assessments of current circumstances must then be understood in the light of histories and personal circumstances. There is a need to involve fathers in direct work and to support men to be a better resource for the child in their care. Practitioners must help develop parenting strategies with them and explore issues such as how they routinely deal with frustration and anger, their tolerance of unexpected demand, linked where necessary to work around substance misuse and their emotional well-being. Practice needs to address men's understanding of the emotional and developmental needs of babies and children and to help them explore their views or gaps in their knowledge about what good parenting looks like.
- 16.3.** Evidence shows that at least some fathers respond positively when they sense that there is a genuine interest being taken in them. The need is to develop an authentic engagement which is much less about assessment checklists and more about seeking out the whole person behind the range of risks and concerns.

## 17. Supporting best practice

- 17.1.** It falls to agency leaders and managers to ensure that working with men is not somehow 'extra' or desirable work – it is essential. An assessment is not an assessment if it does not include (or has at least made every effort to include) the father and any intervention must address both the support needs of, and the risk presented by, male carers. Supervisors and those overseeing front-line practice across the system need to ensure that the assessment and engagement of fathers is evident within the work of their front-line staff. Both internal and partnership audit processes need to focus on how men are being assessed and engaged and outcomes should be reported to safeguarding partners. When examples of best and successful practice are identified these should be highlighted and shared. Feedback from men should be routinely sought so agencies can learn from them what works best and what might be avoided in future.
- 17.2.** Some of the babies in the review were subject to children in need and child protection planning and those plans and associated meetings must maximise the engagement of fathers whenever possible – with necessary safety planning when required. Child protection conference chairs and independent reviewing officers have a key leadership role in overseeing this work operationally and ensuring plans speak to the needs and responsibilities of fathers.
- 17.3.** One of the starting hypotheses for this review was that these men remain 'hidden' or 'invisible' because of practitioner fear and anxiety. This would be not unreasonable – some of the men responsible for this abuse can be scary, physically intimidating and verbally aggressive. The wish to avoid contact with them, to not pursue them proactively if not living in the household or resident but frequently 'unavailable' is an understandable human response.
- 17.4.** There is some evidence that supports this as a factor in the wider research and it has been evident in a number of SCRs. The evidence from our fieldwork, however, and from subsequent roundtable discussions was that fear did not play a significant part and generally was not quoted by practitioners as a limiting factor. Where it was raised as an issue it was not experienced in the same way across the practitioner network, so in the same case some workers were fearful, but others were not.
- 17.5.** That said, it remains beholden on all safeguarding agencies through their supervision and line management arrangements to ensure that the possibility of avoidance driven by fear is openly acknowledged and discussed as needed. Front-line staff need to feel able to raise these anxieties without hesitation and without there being a sense, real or otherwise, that their anxieties will not be taken seriously. Co-working and reflective supervision and discussion can make a

significant contribution. Joint visits are also important and whilst these may place a demand on resources, they remain invaluable in enabling front-line staff to carry out what is often challenging and anxiety-provoking work.



## 18. Service design – challenges to local safeguarding partners

- 18.1.** Frontline staff, and their immediate managers, can only progress improved practice in working with fathers so far. It falls to service leaders to set the necessary conditions within which that work is both enabled and expected.
- 18.2.** The challenges set out below are designed to help multi-agency safeguarding partnerships assess services in their area and to support the development of strategies and action plans that will improve and enhance local services as needed. Some of this work will require the involvement of other partnerships in their areas, most particularly of safeguarding adult boards and community safety partnerships.
- 18.3.** This review has not focused specifically on the impact of COVID-19 but it is important to acknowledge that it will have impacted greatly on the ante and postnatal services and the engagement of men. Local safeguarding partners must ensure that any emerging local or national learning from this review is taken into account in post pandemic recovery plans. Due consideration must be given to any custom and practice which has developed during the last 18 months that may inadvertently exclude men.
- 18.4.** By addressing the questions set out below, partnerships can begin both to benchmark their current provision and to improve and design services to make a positive impact on the safety of babies. We hope and expect that local partnerships will use them as an opportunity to reflect carefully and thoroughly on their policies and practice. Questions and challenges for safeguarding partners can be considered across three dimensions – culture and context; processes; tools, frameworks and services.

**It is the recommendation of this review that all local safeguarding partnerships respond comprehensively to these challenges and develop local strategies and action plans to support improved practice and effective service responses.**

## Culture and context

- What evidence is there that as local leaders you are affirming the need to include fathers, in both universal and safeguarding services?
- Can you develop end-to-end service improvement and oversight designed to maximise the engagement of men?
- What public health messages are you issuing designed to address the issues in this review?
- How is commissioning and service design of 0-19 health services enabling capacity, flexibility and proactive engagement of men and reflecting the key messages of this review?
- How are your local quality assurance and scrutiny arrangements focussing in on this area?
- How well are the different needs of men from black and ethnic minority backgrounds, from different cultures and faiths in local communities understood and addressed?
- How are you endeavouring to ensure that men's views are influencing service design?

## Processes

- How are adult mental health, substance misuse, domestic abuse service providers in your area identifying and responding to their service users as parents? How confident are you that they are commissioning and delivering the right services for men? Are timely and appropriate referrals being made to children's and early help services; do they identify factors that might present a risk to children, especially babies?
- How well are these adult-facing services integrated with children's services?
- How well is Clare's Law understood and promoted in your area?
- How confident are you that information sharing and/or lack of information seeking is not presenting a major safeguarding risk in your area?

## Tools, frameworks and services

- Have you audited the quality of pre-birth assessments, are they undertaken as early as needed and are they informed by information and assessments on a multi-agency basis? Are the histories and backgrounds of both parents included in them routinely?
- Do you ensure that work to engage men and fathers that reflects good outcomes for children is shared across the partnership?

- Are you confident referrals made to adult services are followed up, that assurance is sought that men attend and that the outcomes of the interventions are considered as part of the risk assessment?
- What is the rate of attendance of men at child protection case conferences?
- What arrangements are made for men's involvement in meetings if it is deemed that they are too dangerous to attend?
- How many social care assessments routinely include comprehensive and detailed pictures of fathers?
- How well is supervision and staff support embedded in local agencies? How easy is it for front line staff to express anxiety and fear about working with particular men? What is the response when they do so?
- Are there joint working protocols in place between children's and adults services? Are they well-used and are they effective?
- Are there working protocols in your area covering 'Was not Brought' and 'Bruising in non-mobile babies', are they well communicated and are they effective?
- What joint (across children's and adults) training and workforce development programmes are there in your area that address the issues in this report – including the need to understand addictive behaviours, emotional dysregulation, working with trauma and disorganised attachment and the development of safety planning?

**18.5.** In summary, we believe that improvements in practice must be tackled within four interconnected tiers. One is to focus on the work of front-line staff to better understand men's histories and contexts; secondly, to use that understanding to conduct detailed and specific assessments and set out programmes of work with fathers; thirdly, for supervisors, first line managers and quality assurance processes to routinely focus on the issues set out in this report. Finally, and most critically, we have proposed that safeguarding partners and system leaders address a series of challenges to improve local provision and practice responses to men who might present a risk to babies.

**18.6.** It is only through adoption of this multi-faceted response that there can be real confidence that the abuse and harm examined in this review will be more successfully addressed than it has been to date.

# Conclusion

## 19. Conclusion

- 19.1.** This review set out to explore how well the safeguarding system understands the role of the father/male carer in infants under the age of 1 in order to reduce the number of injuries and serious harm, including death, perpetrated by them. It has identified a number of key learning points about how the safeguarding system could be more effective at engaging, assessing and planning work with men in order to protect children.
- 19.2.** Nearly half of all the cases we reviewed were only known to universal services. The evidence we have gathered supports the view that those services in the antenatal and postnatal period are constructed to meet the needs of women and children. This is as it should be but they need also to be delivered in a way that actively encourages and enables the engagement of men. The review's evidence would suggest that a lot of men are eager to be actively engaged with these services; this includes some men who have gone on to harm their children. Opportunities are being missed for professionals to identify fathers who might need extra support and those who might present some of the risk factors for caring for children safely.
- 19.3.** The evidence from this review highlights that more specialist services need to be better attuned to situations where a number of factors concerning the behaviour and backgrounds of some men may combine together to create risk to babies. The safeguarding system, and professionals working within it, need to be much more alert to these factors and the interplay between them. These factors are:
- Men who have had a background of abusive, neglectful or inconsistent parenting themselves, where there are histories of poor attachment patterns. This can result in poor attachment styles as adults and inappropriate responses to the needs of children, resulting in anger and harm.
  - Men who have histories of impulsive behaviour and low frustration thresholds – in several cases anger was evident in childhood. Several men had no histories of violence but did report punching walls or smashing or throwing things in frustration.
  - 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 mitigate their difficulties with others through an easy default to violence and controlling and angry behaviour.

- Men experiencing external pressures such as those brought about by poverty, mounting debts, deprivation, worklessness, racism and, in several cases for the men we spoke to, very poor relationships with the mothers of the children.

- 19.4.** What became clear from our interviews was that the inflicted injuries often occurred within a context of historical as well as more recent stresses - typically a combination of historical abuse that the men themselves may have suffered as well as significant problems in the days, weeks and months leading up to the actual NAI. 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 what was for many an already low frustration threshold. The injuries inflicted on the baby were undeniably a highly damaging and abusive response to normal infant behaviour (such as crying or being sick) but this behaviour was triggered in the context of all the other stresses that had been accumulating in the man's life up until that point.
- 19.5.** As well as identifying issues connected to characteristics about the behaviour of men who have physically abused babies, the review has also highlighted a number of other important issues that warrant further consideration by local safeguarding partners, commissioners and government. There is a distinct lack of detailed **research knowledge** about this group of men and this form of abuse. This stands in stark contrast to the body of work that has developed in response to child sexual abuse where it is possible to locate considerable research carried out with abusers, patterns of abusive behaviour identified, and therapeutic and treatment responses described. No such parallel work is available in relation to this group of people who abuse children. This is particularly noteworthy given its prevalence and its potentially very damaging and sometimes fatal consequences for baby and child victims.
- 19.6.** This review found no one particular "identifier" that could safely be used as a predictor of risk to babies. Instead we identified a range of factors, which when they combine present what should be recognisable warning signs that indicate risk. There is also the element of chance – what happens in the moment and cannot be predicted. Further research conducted with perpetrators would deepen the understanding of their backgrounds, characteristics and behaviours as well as exploring what happened in the moment of abuse, the triggers and prevailing circumstances at that time.
- 19.7.** Men remain peripheral to **service design** and to operational service delivery in **antenatal care** and early family support. Opportunities for engagement and efforts to enable men to be the best fathers they can be are not maximised: far greater proportionate effort and attention is given to enable mothers to be the best parents they can be. Men can get lost and become bystanders. The opportunity for the **early identification** of fathers who might need extra support and those who might present a potential risk is not adequately or consistently achieved, nor is appropriate support readily available.

- 19.8.** This low-level engagement continues into **statutory service** provision for families in contact with children's social care. Too often, when men are engaged, they are seen in a simplistic binary way, good or bad, supportive or a risk. Men will frequently be both and an approach that is characterised by support and challenge, by both listening to and holding to account is required.
- 19.9.** For those men who have suffered repeated, multiple childhood abuse and trauma over a long period of time, there are **limitations to any intervention or treatment**. Assessments of risks needed to be realistic about the potential for change – for some it will be limited and the focus needs to be more on external monitoring rather than expecting significant change through therapy or treatment.
- 19.10.** Finally, the invisibility of men extends beyond service design and delivery to the completion of both **SCRs and LCSPRs** where either men are often not interviewed at all (accepting that sometimes they refuse to cooperate and sometimes impending criminal prosecutions can make that difficult). Equally when they are spoken to, the evidence is that those interviews do not explore their histories, the context for the abuse or harm or their experiences of services.
- 19.11.** In the section on statutory service provision, we quoted some recent research, 'Up Against It' on the presence of men in recurrent care proceedings. An earlier version of that research was published as 'I had no hope, I had no help at all'<sup>40</sup> which concluded:
- “Our position... is a commitment to gender equity in relation to parenting roles and responsibilities? Supporting fathers and mothers cannot be seen as a zero-sum game, where service development for one necessarily diminishes or sits in opposition with the other.....we are arguing for the development of services that hold men equally accountable for the safe care of children and avoid positioning women as disproportionately responsible for children's welfare..... Without this (increased levels of investment), highly marginalised recurrent fathers, their families, and the practitioners trying to support them are likely to remain up against it”.
- 19.12.** This is an argument that this review supports – not just in relation to 'recurrent' men but to the broader field of ante- and postnatal care, from universal to specialist safeguarding services.
- 19.13.** One of the consequences of the failure to routinely find, engage and assess men is that the protection of children to whom they present a risk often falls on mothers. Too often mothers are left to manage those risks on their own and are faced with the potential or real removal of their children, if they are seen to have failed to protect their children.

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40 Philip, Georgia and Youansamouth, Lindsay and Bedston, Stuart and Broadhurst, Karen and Hu, Yang and Clifton, John and Brandon, Marian (2020) "I Had No Hope, I Had No Help at All": Insights from a First Study of Fathers and Recurrent Care Proceedings

**19.14.** In summary, we believe that those leading and commissioning services and practitioners active in this work should do more, much more, to make the seemingly invisible visible and the hidden known. Much more must be done to offer the necessary support, challenge and engagement with the men with whom they work or with whom they should be working in order to prevent more babies suffering the harm described in this report.



# Recommendations

## 20. Recommendations

- 20.1.** This review has explored a number of issues that relate to the role of men in the birth, upbringing and safeguarding of children, especially in their first months of life. The Panel believes that action is required at national, local and practitioner level. A previous section made a number of proposals about how local practice might improve and develop. The recommendations below focus on national policy.
- 20.2.** The moral case behind these recommendations is inarguable but there is also a powerful economic case. Whilst no price can be put on the harm to the lives of these babies and their families, it is important to acknowledge that there are considerable financial consequences of the abuse they suffer. Many children harmed as babies face a lifetime of disabilities, some requiring 24-hour care. A study in Canada estimated the total cost to the public purse of AHTs suffered by 64 babies between 2002-14 to be over \$350 million (£252 million).<sup>41</sup> There is therefore an economic as well as a moral imperative for change.
- 20.3.** The change needed requires strategic, cross-government approaches to ensure that all relevant policies and programmes acknowledge and reflect the importance of working with fathers and male carers. These changes are essential to improving children's wellbeing and maximising their safety. There is a pressing need to improve the effectiveness of both prevention and early intervention services as well as those which have a statutory child protection focus. Intervention and improvements are required across the continuum. There is a real and associated need for rigorous evaluation to find out what works in practice.
- 20.4.** The Panel has three national recommendations which are focussed on improvements needed in both universal and specialist safeguarding provision and all of which require some investment.

### Recommendation 1

Children's social care needs investment to develop practices with men and fathers within high risk families. Children in need and children on child protection plans are by definition those most at risk. There needs to be a greater confidence that the work with those children is addressing all those risks and that men are being both challenged and supported to be safe carers. Funding some practice development sites would enable models of good practice to be identified and disseminated.

Particular attention could be given to strengthening the family safeguarding model led by Hertfordshire and being developed in other areas, to include a specific strand of work with fathers which would build on the co-working a model that is already addressing

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<sup>41</sup> The lifetime costs of paediatric abusive head trauma and a cost-effectiveness analysis of the 'Period of Purple' crying program in British Columbia, Canada – ScienceDirect

a number of the issues identified in this report – specifically bringing together domestic abuse, mental health and substance abuse expertise with children's practitioners.

**The Panel recommends that Government funding is identified to enable a number of local areas to develop models of good practice in working with fathers. They should cover a mixture of areas with different socio-economic, ethnic and cultural characteristics so that particular focus can be given to developing models of intervention that reflect and respond to different communities. Future dissemination of learning should clearly identify 'what worked with who and why'.**

## Recommendation 2

'End-to-end service redesign pilots'. This report sets out clearly the complex and interrelated nature of the factors that combine to represent a risk to babies from their fathers and those in a father role. It also is clear in describing how those factors are evident in universal service provision and remain so through specialist services including care provision. It also looks at the need to better integrate children's services with adult provision, especially when responding to domestic abuse, adult mental health and substance misuse issues. What is required are service designs that reflect that complexity and address the need for an integrated and system wide response that involves all the relevant agencies.

**The Panel recommends that a number of pilot areas are identified and funded by Government to develop 'end-to-end', multi-agency integrated service re-design to address the issues identified in this review. The pilots need to address how they will:**

- Develop their ante- and post-natal health provision to include fully fathers and to include extra support to those who need it and increase their ability to early identify risk factors
- Ensure a greater integration of children's and adult service provision, especially adult mental health and substance misuse services,
- Integrate their response to the Domestic Abuse Act 2021, how they will ensure a focus on the risks to babies and children and how they will work with perpetrators
- Ensure that children's social care lead on the development of practice that improves the engagement and assessment of men involved in children in need, child protection and children in care services
- Develop their leaving care services to ensure they address the need for preparation and support for parenthood

Those areas identified should similarly reflect the needs of different communities and levels of deprivation levels in order to maximise learning.

### **Recommendation 3**

Research – throughout this report, we have identified areas where not enough is known nor understood about the causal factors of death and serious harm to babies. In particular, a more detailed and thorough understanding is needed of fathers' backgrounds, characteristics and trigger factors for the abuse.

**The Panel recommends that research is commissioned by government to enable a better understanding of the psychology and behaviour patterns of men who have abused babies through NAI. Part of this research should be to explore the gender issues raised in this report, including why some of the experiences and factors described and which are experienced by men and women alike, can result in more men harming babies than women.**

- 20.5.** In addition, the Panel has identified five national reviews, policy challenges and strategic developments that are being progressed and that could, with some small changes of emphasis, very significantly increase and enhance the ways in which fathers are engaged in services, especially those at the universal and early intervention level.

### **'The Best Start for Life: A Vision for first 1001 Critical Days' (The Leadsom Review)**

The first phase of this review was published in March 2021 and set out a number of action areas for further work during the second phase of the review. These include: seamless support and 'Family Hubs' to make that support easy to access; the provision of information and advice with a workforce that is highly skilled and able to meet the changing needs of families. There is a priority given to developing 'the leadership for change, ensuring local and national accountability and building the economic case'

The Panel recommends that:

- As this develops, clear and explicit focus is given on maximising the input of fathers, including and especially those who might, given their circumstances, present a risk to babies.
- The programme pays due regard to the available research on father's involvement in Sure Start and other early years and early help provision, and that the involvement and engagement of fathers is a specific strand in any future funding and evaluation.

### **Family Hubs**

Stemming from the Leadsom Review, the government is investing in family hubs across the country where families can go with their children to access help that might be otherwise hard to find and where they can meet health visitors, get access to classes on parenting and receive wider support.

The Panel recommends that:

- The purpose and design of family hubs reflects the importance of meeting the needs of both parents, ensuring good access for, and engagement with women and men.
- Funding should be made available to develop services designed to respond to the findings of this review and that future evaluation maintains a focus on the engagement of fathers and male carers. These services need to focus on the early identification of men for whom fatherhood might be a source of anxiety; that can explore men's own experiences of family life and that can help prepare them for the routine challenges and demands of parenting.

## **‘Supporting Families 2021-22 and Beyond’.**

Published in March 2021, ‘Supporting Families’ introduces the next phase of the ‘Troubled Families’ programme, which has been in place since 2012. It identifies six areas of focus including: improving children’s life chances through extra support where needed, improving living standards for families experiencing or at risk of worklessness, homelessness or financial difficulties, support for families affected by domestic abuse and support for parents and children with a range of physical and mental health needs.

The policy documentation for Supporting Families describes the need to develop a ‘whole family’ approach. The Panel supports this but it is our view that unless fathers and men are specifically named then the attention given to their needs and engagement will be lacking.

The Panel recommends that:

- As this programme develops and is rolled out, specific expectations are set for the increased and explicit engagement of fathers (including birth, step and non-resident fathers). This engagement should not focus solely on a reduction in the perpetration of domestic abuse but also more positively with an increased expectation and support to become more involved and positive parents.
- The engagement of fathers is a specific focus in any future evaluation of the programme.

## **Better Births**

This remains the blueprint for the continuing modernisation of the midwifery service and the progress report, ‘Better Births Four Years On’ describes a considerable amount of progress made.

However, it acknowledges there is more to do, including in addressing inequalities of outcomes for people from Black and ethnic minority backgrounds and more deprived communities. ‘Going forward, the programme will continue to work in partnership with national organisations and local systems to harness the collective drive and will to change and improve maternity care for women and families’.

The Panel recommends that:

- ‘Families’ is more specifically defined and understood as ‘fathers and other family members’ to ensure that there is dedicated focus and attention to the role of fathers and men.
- Action is taken to secure the necessary cultural change in health, including nursing services, to engage fathers better. This should involve specific training, and making sure that practitioners have the necessary training, time, capacity to change practice.
- Early adopter sites should be enabled and encouraged to develop programmes to address the findings in this report.

- The impact of Better Births on the engagement of men is subject to separate evaluation.

## The Domestic Abuse Act 2021

The Domestic Abuse Act 2021 recognises children as victims of domestic abuse for the first time.

The Panel recommends that:

- The development of perpetrator strategies includes the need to address the protection of babies and children as well as partners.
- Any future investment in domestic abuse provision and/or evaluation of the impact of the Act and the Home Office funded research into domestic abuse perpetrators must include their impact on babies and children.

These ongoing strands of work offer an opportunity to inject a new focus on the role of fathers and male carers across a wide vista of government policy and local implementation. Rigorous evaluation is needed, with a specific focus on engagement of, and impact on fathers. This will maximise the opportunity to build a strong evidence base about what works in engaging and supporting men to better protect small babies in their care.

## The Inspectorates

Finally, the important and service-shaping role of the inspectorates needs to be considered.

The Panel is not seeking any additional inspection burden on the safeguarding system, but we are aware that the inspectorates and especially Ofsted have a national overview of service delivery and of the whole range of practice standards.

The Panel recommends that:

- Any future inspections carried out by Ofsted, CQC and HMICFRS, whether through the JTAI or ILACS frameworks, take account of this report and its findings in terms the extent to which agencies are responding to its contents.

**20.6.** In conclusion', harm to babies through non-accidental injury is a consistent and significant issue. As a Panel we see the terrible human cost set out in the cases that come before us every week. Rapid and significant changes are needed in policy and practice so that there is a whole system approach to working more effectively with men. Change is essential if fewer babies and their families are to experience such the trauma. We hope that the recommendations in this report and its challenges to local leaders will help drive that change.

# Appendices



## Appendix A: Fieldwork areas

- Barnsley
- Bristol
- Cornwall
- Derbyshire
- Devon
- East Riding
- East Sussex
- Isle of Wight
- Lancashire
- Leicester
- Leicestershire
- Merton
- Rotherham
- Sandwell
- Stockport
- Stockton
- Torbay
- West Sussex
- Wokingham

