Invisible/Unseen Men – Practitioner Briefing

Welcome, this briefing aims to help practitioners and their managers by summarising the findings from the Child Safeguarding Practice Review Panel's published third national review The Myth of Invisible Men in September 2021. The messages in this briefing are just as important for those practitioners working with adults who are parents.

This Review came about as a result of babies under 1 being the subject of 35% of all serious incident notifications; 257 since July 2018. Rapid Reviews often referred to male carers as 'invisible'- yet they are more likely to cause harm. This review looked at the circumstances of 23 babies under-one-year-old in detail who have been harmed or killed by their fathers or other males in a caring role. The review was informed by: interviews with eight male perpetrators serving prison sentences for harming babies; in-depth research into cases involving 23 babies that have been notified to the Panel; a review of the research literature; and roundtable discussions and one-to-one meetings with key stakeholders. The views of practitioners and perpetrators were sought.

Key findings;

Risk factors: The review uses information gathered from interviews with perpetrators, analysis of serious incidents and a review of the literature to identify the following potential risk factors: Men whose own parents were abusive, neglectful or inconsistent. This can result in poor attachment styles as adults and inappropriate responses to the needs of children. Men who have histories of impulsive behaviour and low frustration thresholds. Men who abuse substances, especially drugs, to a degree that encourages increased levels of stress and anxiety, sleeplessness, lowered levels of frustration tolerance, heightened impulsivity, poor emotional and behavioural regulation and poor decision making. Men who have low self-esteem, or other issues around mental and emotional health. Men who become parents at a young age, including care leavers. Men who mitigate their difficulties with others through violence and controlling and angry behaviour, including some who are perpetrators of DA. Men experiencing external pressures such as those brought about by poverty, debts, deprivation, worklessness, racism and poor relationships with the mothers of the children. Inflicted injuries often occurred during a time of heightened stress. Significant relationship problems were common, within a spiralling negative cycle of drug abuse, deterioration in mental state and poor decision making, and a lowering of frustration threshold. The injuries inflicted on the baby were often triggered by normal infant behaviour, such as crying or being sick, in the context of a mixture of the risk factors identified above.

Putting learning into practice

Working with and engaging fathers/male carers is not an "add-on" but an essential part of working with families.

During pregnancy and after birth, make active enquiries about the child's father (and other potential carers), from all sources, not just from the mother, and make direct contact with them.

Encourage and support the mother to see the importance of the role of the significant other in the child's life.

These men inflicted terrible injuries on babies and are responsible for their actions. As a system our knowledge of men is too often weak and ineffective, this excludes the men that need support and would like support and enables those that might pose a risk to hide in plain sight. The review concluded that the entire system makes it too easy for men who pose a risk to be unseen.

So think about the learning from this Review and what it means for your practice. How confident are you in your work with men? What do you know about the history of the men you work with? Is there substance misuse, has this been normalised? What about domestic abuse or mental ill health? Do you routinely check in with fathers as you do with mums? What do they think? How do you know? What would you do if you had a concern? The men who caused harm to these babies were not invisible they were unseen.

Key Information: 92 serious incident notifications were reviewed. At the time of the abuse: 45 known to universal services - 24 known to Early Help - 12 Children in need and 11 Child Protection Plans

Risk Factors: 59 featured domestic abuse, 32 fathers had mental ill health, 30 were young parents, 5 were care leavers, 81 of the babies were harmed by their birth fathers, 11 by another male carer.

Key findings continued;

Service response; All services need to do more to involve and 'see' men. Men who want to be involved are routinely excluded from universal and specialist services. The same structures enable those men who present a risk not to be involved. For example; services covering antenatal and early months of life in England remain predominantly women-facing, and are less accessible to fathers. For example, antenatal services are rarely provided out of hours or at weekends and aren't designed to maximise fathers' involvement. As a result, fathers are not provided with important information about becoming a parent, such as the impact of crying and how to feed and handle babies safely. Due to cuts in funding there was a decline in the provision of some services which meant limited capacity to target fathers. This means that the potential to use impending fatherhood as a "reachable moment" is often lost. There is a reduced ability to identify men whose vulnerabilities might require further specialist input and it is less likely that the risks they may present to their child are identified and acted upon.

Issues with information sharing were found particular within/between health services. Evidence of information not being sought within statutory safeguarding services. The whole picture was not seen. Three key issues identified:

- **A lack of patient record integration across the health service, most noticeably in communication between midwives, HVs and GPs. Some risk factors may only be known to GPs and they require the consent of the father to share information with others. Health records for babies only allow the inclusion of one adult (the mother), so records relating to fathers are held separately and family records cannot be seen in a joined-up way.**
- **GDPR was seen by many to have made information sharing less effective and more complex. It was seen to limit practitioners' ability to use pre-birth protocols/procedures to trigger assessments. Decisions about whether the threshold of S47 has been reached can only be made if all relevant information is known, but the information can only be shared once the threshold has been reached.**
- **Practitioners were unclear about thresholds for sharing information/referring cases into children's services. Legislation and guidance was in place to enable information sharing, but organisational culture and leadership caused variation in how well this happened in practice.**

Insufficient linkage between children and adult services; those adults presenting a lower level of need to adult services can present the highest level of need to children services. DA perpetrator programmes are not universally available and where they are the impact on the safety/wellbeing of children is insufficiently evaluated. They often focus on challenging men about their behaviour and the risk they pose to adults, but do not consistently challenge them on the risk they pose as fathers.

Evidence from the national panel research shows that some fathers responded positively when they sensed a genuine interest being taken in them.

Please access the Pan Bedfordshire Child Protection Procedures and register for updates and information on the ICON programme.