

The Myth of Invisible Men

Working with fathers to become more effective at safeguarding under 1's

(from non-accidental injury caused by male carers)

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.

The Child Safeguarding Review Practice Panel reviewed 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.



Out of the 92 cases reviewed, 4 cases had fathers that were the convicted perpetrators, in addition:

- 4 cases were trials that were on-going at time of the review (and in 3 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.

The Panel Report highlights:

- 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 information seeking.

- 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, hence the term 'invisible men'.

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.

Service design Culture and context: processes, tools, frameworks and services

Supporting best practice role of supervision and first line managers; exploring fear and anxiety; focussing quality assurance systems

Engaging and assessing men's role of supervision and first line managers; exploring fear and anxiety; focussing quality assurance systems

Understanding men's lives and their experiences Exploring ideas of fatherhood, race, ethnicity, personal histories

The 3 report recommendations:

- 1 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'.
- 2 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 the review.
- 3 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.

Understand men's lives and their experiences