June 2023 | Understanding Evidence and Practice

# Working with male carers to

# REDUCE NON-ACCIDENTAL INJURY TO INFANTS UNDER 1 YEAR OLD

What Works Centre for Children & Families

foundations.org.uk

# ACKNOWLEDGEMENTS

**The authors acknowledge the contribution of colleagues from Foundations, the national What Works Centre for Children & Families, including Anna Bacchoo, Nimal Jude, Ben Moffat, and Fardawza Ahmed. Thank you also to the Child Safeguarding Practice Review Panel for their support in providing case studies for this report.**

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## About Foundations

At Foundations, the national What Works Centre for Children & Families, we believe all children should have the foundational relationships they need to thrive in life.

By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home and lead happier, healthier lives.

Foundations was formed through the merger of What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF).

To find out more, visit our website at: www.foundations.org.uk

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THE CHILD
**SAFEGUARDING**
PRACTICE REVIEW PANEL

# ABOUT THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL

The Child Safeguarding Practice Review Panel is responsible at a national level for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. The Children and Social Work Act 2017 provided for the creation of a new Child Safeguarding Practice Review Panel, and statutory guidance on 'Working Together to Safeguard Children 2018' sets out how the Panel operates and works with safeguarding partnerships. The Panel is appointed by the Secretary of State for Education but is independent of Government.

- We have a shared aim with safeguarding partners in identifying improvements to practice and protecting children from harm. We share concerns, highlight commonly recurring areas that may need further investigation (whether by local or national review), and share learning, including from success, that could lead to improvements elsewhere. We want national and local reviews to focus on improving learning, professional practice and outcomes for children.

Local authorities should notify the Panel:

- If a child dies or is seriously harmed and abuse or neglect is known or suspected:
  - in their area
  - outside of England, but they're normally resident in their area.
- To report the death of children looked after by a local authority whether or not abuse or neglect is known or suspected.

To find out more, visit: www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

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This joint briefing from the Child Safeguarding Practice Review Panel (the Panel) and Foundations - What Works Centre for Children & Families shares information arising from work undertaken by the Panel and Foundations with safeguarding partners and those working in child protection.

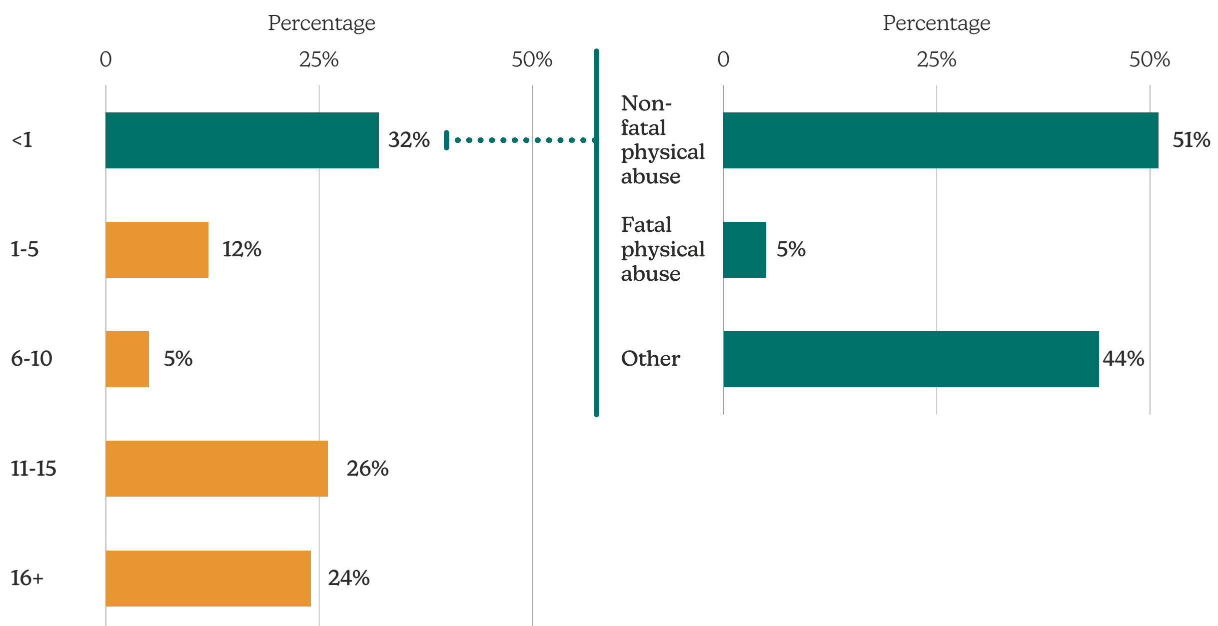
This paper explores current practice and evidence base relating to working with fathers to reduce non-accidental injury (NAI) in infants under 1 year old. It builds upon work that Foundations were commissioned to carry out by the Department for Education, and the previous work of the Panel.

The aim of this briefing is to support safeguarding partners in reviewing their current policies on working with fathers and to make recommendations on how the evidence base and national guidelines can be further developed.

# BACKGROUND

The Panel reviews cases where children have died or been seriously harmed, and abuse or neglect is known or suspected. A large proportion of the serious incidents notified to the Panel are about young infants. In 2021, 32% of serious incident notifications were about children less than a year old. Of the 129 infants under 1 who were notified in 2021, six (5%) had died as a result of physical abuse, a further 66 (51%) suffered serious but non-fatal physical abuse, and 57 (44%) were subject to other forms of serious or fatal harm, including neglect and sudden unexpected death in infancy.

**Figure 1: Number of children subject to serious or fatal harm in 2021**




The particular vulnerability of infants under the age of 1 was highlighted in the [2021 annual report of the Panel.](#) This emphasised the importance of exploring the vulnerability of babies under 1, in depth, with both parents. The Panel's third national review, [The Myth of Invisible Men](#), specifically explored the role of fathers and male carers in relation to non-accidental injuries in infants. This review included in-depth fieldwork into cases involving 23 babies, and, uniquely, interviews with eight male perpetrators who were currently serving prison sentences for harming babies.

The Panel found that, for this group of men, the role that they play in a child's life, their history of parenting, and their own childhood experiences are too frequently overlooked by those services with responsibilities for safeguarding children and supporting parents. The Panel's review identified the significance of men who have had a background of

abusive, neglectful or inconsistent parenting themselves, how this can lead to poor mental health, and, in turn, how this may be exacerbated by substance misuse, increased levels of stress and anxiety, heightened impulsivity, poor emotional and behavioural regulation and poor decision making. Living with the pressures of poverty, worklessness, racism and other social or systemic stresses can exacerbate these risks, as can the co-existence of domestic abuse and attempts by some men to mitigate their difficulties through violent and controlling behaviour. The sample of Safeguarding Partnerships' annual reports analysed by Foundations highlighted the variation in approaches to engaging with fathers and male carers to reduce NAI to under 1s.

# THE EVIDENCE BASE

Two recent research reviews considered risk factors for NAI of infants by fathers and how UK safeguarding services prevent and respond to these instances. The most comprehensive of the current evidence is the Fatherhood Institute's 2021 rapid evidence review that informed the Panel's The Myth of Invisible Men report. Foundations carried out additional rapid evidence summaries to build upon the Fatherhood Institute's evidence review, given the limited evidence base for the specific group of fathers and infants.

It was found that there is limited research on these topics, with a limited number of existing small-scale studies that cannot infer causality. Mixed evidence for infant crying and fathers' poor mental health and substance misuse as risk factors was indicated. The review of services found that there was no routine engagement with fathers around NAI by universal services and a tendency to underestimate the value of working with fathers. Services that do address parental risk factors for NAI are under-evaluated.

The three rapid evidence summaries conducted by Foundations looked beyond fathers and infants under 1 and included evidence relating to children and parents more broadly. Key points from these evidence summaries are presented below.

## What are the risk factors for the physical abuse of children by parents?

- Poor social information processing, poor mental health, substance use/misuse, financial stress, and experiencing abuse as a child oneself were all consistent risk factors for parental physical abuse of children (including those under 1 year old).
- Research includes predominantly female participants, making it difficult to identify risk factors that may be unique to men. Very little is known about male caregivers who are not biological fathers.

## What is the evidence base for parenting interventions?

- The most consistent evidence for interventions that reduce the risk of physical abuse are for cognitive-behavioural approaches that focus on not just the parent-infant relationship but familial relationships more generally.
- Interventions often do not account for the experiences of demographically diverse groups; evaluations often take place with participants of white ethnicity and higher socio-economic status.

## What are the barriers to engaging men in parenting interventions?

- Interventions can be overly focused on “mothering” as opposed to “parenting”; reducing the sense of a female-dominated space within an intervention can be useful to uptake and engagement.
- Male carers face a number of practical barriers, such as finding time around employment to participate, and finding childcare during participation. Interventions could support childcare, be flexible in delivery and offer transportation or food to help overcome financial barriers.

# CURRENT PRACTICE

Foundations have examined existing practice through two exercises: an analysis based on desktop deep-dive audits of a sample of 25 Safeguarding Partnerships' yearly reports from 2020-21 and a non-systematic practice mapping exercise across England to identify practice that focuses on working with fathers, working with infants under 1 or non-accidental injury.

The 25 Safeguarding Partnership reports were reviewed using an integrated audit tool developed by Foundations and members of the Child Safeguarding Practice Review Panel. The tool incorporated evaluations of prioritisation, progress, use of evidence and impact, dissemination and embedding of learning, and the degree to which the report is evidence-based.

One part of the analysis is focussed on how the Safeguarding Partnerships are seeking to reduce NAI in infants under 1 year old, any activities specifically targeted at men who care for under 1s, and any other practices and interventions that seek to safeguard under 1s.

The non-systematic practice mapping was informed by the Safeguarding Annual Reports analysis, Foundations' networks, and specific external communications on the subject. The exercise found that, whilst there is currently a dearth of evidence about what works, a number of evaluations are in progress, and this should therefore be seen as a developing evidence base.

## Reducing NAI in infants under 1 year old

Of the 25 Safeguarding Partnership reports included in this analysis, 13 included activities aimed at reducing NAI in infants under 1 year old. Six of these used the ICON programme. In addition to these 13, one identified improving engagement with fathers and male carers as a priority area for improvement in 2021-22 but did not outline any actions to be taken.

Practice mapping found that the most commonly used programme (ICON) is already in the process of being evaluated by the National Institute of Health Research, with results expected in late 2023. This research aims to: evaluate the effectiveness of the ICON programme in reducing the incidence of abusive head trauma in young infants, looking at how ICON impacts the incidence of abusive head trauma and the factors amongst families and professionals that determine the reach of the ICON programme; and whether ICON is cost-effective compared to normal care.

Foundations is carrying out a feasibility study for another widely-used intervention (For Baby's Sake). This aims to explore evidence of promise and readiness for impact evaluation. Two further small-scale projects are being supported by Foundations to develop an early evaluation about what works for this cohort.

## Activities specifically targeting men who care for infants under 1 year old

In addition to the 13 mentioned above, three mentioned programmes targeted at men who care for infants under 1 are aimed at accidental injury, as well as NAI. Reports included "hidden men" training, learning events, and safer sleeping training for men. One report in the 13 mentioned above also mentioned specific activities targeted at male carers.

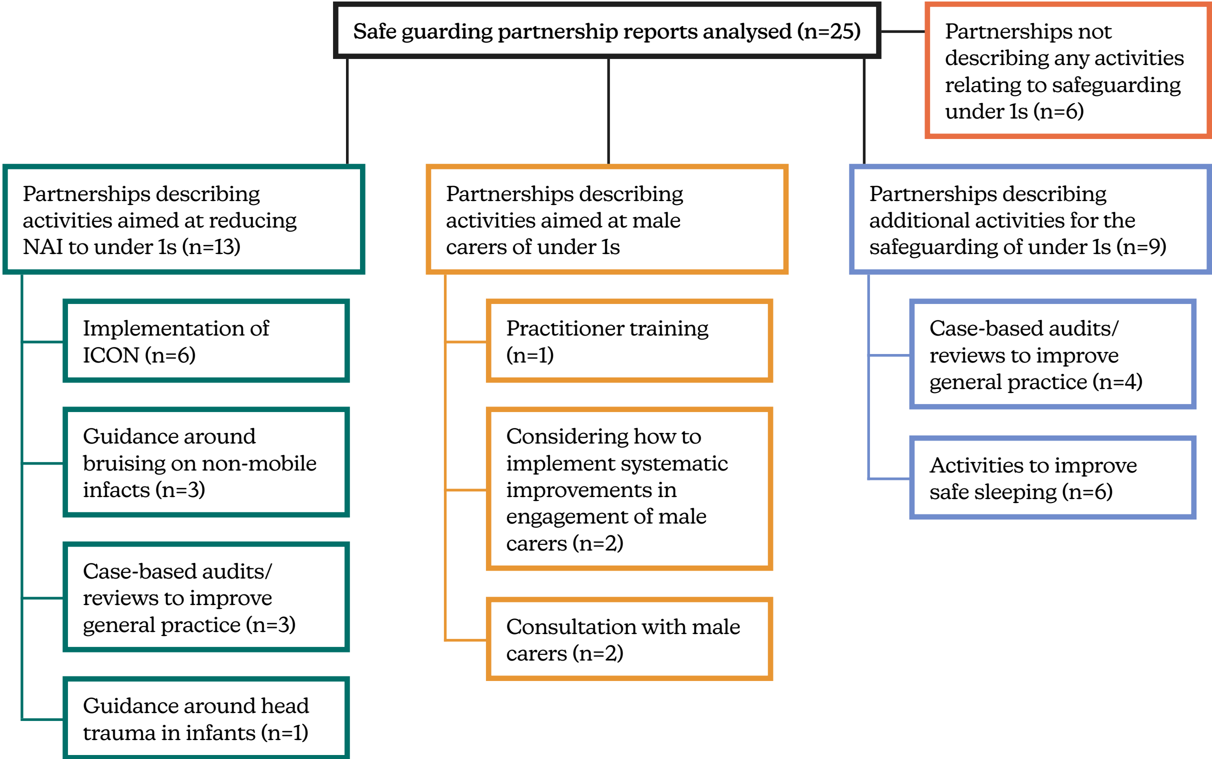
Foundations has also commissioned an evaluation of ISAFE (Improving Safeguarding through Audited Father-Engagement), which aims to improve engagement with fathers (including stepfathers, mothers' boyfriends and other significant men in children's lives) by local authority children's services. ISAFE is an online training package developed by the Fatherhood Institute and CASCADE (the Children's Social Care Research and Development Centre, based at Cardiff University).

ISAFE aims to increase engagement with fathers, which in turn is intended to enable better identification of risk in families and better-informed, more assertive decision-making. The evaluation includes a full-scale randomised controlled trial (RCT) to assess the efficacy of the ISAFE training in eight English local authorities.

# Additional practices and interventions which seek to safeguard infants under 1 year old

Outside the categories above, eight Safeguarding Partnership reports included practices and interventions that seek to safeguard under 1s, with safer sleeping a common theme. Four of these were in addition to the 13 who mentioned activities aimed at reducing NAI in infants under 1 that are mentioned above.

**Figure 2: Activities related to safeguarding under 1s identified in 25 Safeguarding Partnerships' yearly reports**




*note: some Safeguarding Partners' reports appear in more than one category

# Case Studies

### Case study 1: Derbyshire

In January 2023, the Derby and Derbyshire Safeguarding Children Partnership published a local child safeguarding practice review (LCSPR) focusing on the vulnerability and needs of young infants. The review considered the experiences of two babies who had suffered serious harm following non-accidental injuries.

#### The infants' lived experiences

The first infant was born prematurely with significant and enduring health problems. The family had been known to children's social care for 18 months with concerns about the home conditions, possible neglect of the older siblings, parental physical and mental health problems, and parental engagement with services. The father's engagement with social care was particularly noted to be poor. There was one recorded incident of verbal abuse on the neonatal unit. Nineteen days after discharge from the neonatal unit, the infant was found on a routine follow-up to have six fractured ribs and bruising to the feet and back. The injuries were deemed to have been caused by robust handling linked to the child's underlying medical vulnerability.

> **Learning Point**
> Many health professionals appear to have accepted a narrative for this family of parents in difficult circumstances dealing stoically and caringly with the additional burden of a child with significant additional needs... [this] did not facilitate a more objective assessment of how the family was functioning... opportunities were missed to work more collaboratively and effectively with other agencies.

The other infant was born into a reconstituted family of mother, birth father, and a maternal half sibling. There was a history of violence in the mother's relationship with her previous partner. At the age of three and a half months, the infant was taken to hospital with a fever and was found to have 16 non-accidental fractures. Previously the parents had repeatedly been to the GP with concerns about feeding problems and weight gain. A referral for a paediatric opinion was made.

#### Key learning themes

As well as reinforcing the centrality of multi-agency team working, strong leadership and culture, and giving pointers to effective multi-agency practice, the LCSPR identified several key learning points. The intrinsic vulnerability of infants needs to be better integrated into professional thinking, and it is vital that professionals are focussed on identifying additional vulnerabilities of an infant or stresses within the family that could escalate that risk to a level requiring some preventative and protective intervention. The LCSPR also found that supervision and support that is reflective, as well as task-based, provides overview and objectivity to avoid practitioners becoming enmeshed in a family script or dominant narrative and, can facilitate "thinking the unthinkable".

### Actions taken in response

The Safeguarding Children Partnership appointed a Keeping Babies Safe Strategic Lead to oversee the delivery of a multi-agency action plan through their Steering Group. This included: a review of all open cases of children under 1; the development of the Keeping Babies Safe Strategy; a multi-agency audit focusing on the quality of services provided to families to keep babies safe, including the assessment of risk and needs in babies; a series of briefings with front line staff and managers; and the training of over 100 Keeping Babies Safe Champions and the implementation of the guidance Every Baby Matters: Identifying Vulnerability.

**Learning Point:**

There was little if any recognition of the possible impact of the stress of the ongoing conflict between mother and her ex-partner or of the feeding difficulties being assessed either as a significant additional stress or as possibly being externally mediated, rather than resulting from an intrinsic health problem.

## Case study 2: Wiltshire

In 2022 the Wiltshire Safeguarding Vulnerable People Partnership published an LCSPR of a 3-month-old infant, Eva, who died following abusive head trauma.

### The infant's lived experience

This young baby was the first child of her parents, both of whom were known to the police because of suspected drug use and drug dealing. Beyond this, the parents were known to universal services. A safeguarding risk assessment had been carried out by midwifery during pregnancy, which had identified the parents' cannabis use. Further police incidents relating to cannabis use were noted during the antenatal period, although this was not known by other professionals. On routine health visitor contacts following the birth, both parents were observed caring for Eva who appeared content, happy and cared for; a 'loving and warm interaction' was observed between Eva and her parents.

**Learning Point:**

Problematic cannabis use was one of the most prevalent themes in this case. More potent, modern forms of street-based cannabis can be linked to greater levels of anxiety and depression, sleeplessness and decreased impulse control, as well as impacting on family finances and subsequent stress.

> **"It is within this context that the apparent normalisation or at least the often unexplored and unassessed nature of someone's use of the drug needs to be understood... It is the use of these forms of cannabis when combined with other risk factors that can expose children, and especially babies, to harm, often significant and sometimes fatal."**

### Key learning themes

The review identified key learning themes in relation to professionals' ability to recognise and assess problematic cannabis use and its potential impact on risks to vulnerable children; several issues relating to the collation and sharing of information; the challenges of seeing the child within adult-facing services; and in the extent to which services respond differently to mothers as opposed to fathers.

### Actions taken in response

The Safeguarding Partners, together with neighbouring authorities, established a cross-borough Safeguarding Under 1 Year's Steering Group. The group were particularly tasked with exploring work to engage fathers in ante- and post-natal care, and to look at ways of embedding and mainstreaming the improvements identified in the review.

The Safeguarding Partnership committed to working with the Community Safety Partnership in the recommissioning of substance misuse services, with awareness raising around the harmful effects of street cannabis and a focus on those entering parenthood.

A new project, Dads Matter Too, has been established to provide intensive support for fathers and develop understanding of and practice in how best to engage men as fathers.

**Learning Point:**

All the evidence is that babies under 1 year old are the most vulnerable group of children in the community. Responding to them in the same way as older children is not sufficient and treating all children aged 0–18 years the same does not properly reflect the differential risks faced across the age spectrum.

[Safeguarding Partners and individual agencies] should actively adopt a more differentiated and nuanced approach to the development of core safeguarding practice and policies to reflect the particular vulnerabilities of unborn babies and those under 1 year old.

# RECOMMENDATIONS

## Recommendations for policy & practice

- **Safeguarding Partnerships should focus on offering interventions with the strongest evidence base.** The most consistent evidence for interventions that reduce the risk of physical abuse are for cognitive-behavioural approaches that focus on not just the parent-infant relationship, but familial relationships more generally.
- **Safeguarding Partnerships should examine how their service offer increases engagement with fathers and male carers.** Currently, there is often no routine engagement with fathers around NAI by universal services, and a tendency to underestimate the value of working with fathers.
- **Safeguarding Partnerships should identify and develop a strategy to address current barriers to the uptake of services for fathers and male carers.** Reducing the sense of a female-dominated space within an intervention can be useful in increasing uptake and engagement, as well as considering how to address financial and practical barriers around employment and childcare. For example, interventions could support childcare, be flexible in delivery and offer transportation or food to help overcome financial barriers.
- **Safeguarding Partnerships should record specific data on fathers and male carers.** This should be done as part of the routine data collection by services within the Safeguarding Partnership.

## Recommendations for research

- **Future research should build upon existing and ongoing studies.** While we were pleased to see that some popular interventions are in the process of being evaluated, there is generally a lack of robust evidence in this space, and we would welcome further research to develop the evidence base around working with fathers and male carers to reduce NAI.
- **Research with a specific focus on fathers and male carers across demographically diverse groups is needed.** Currently, research included predominantly female participants. We would welcome research to specifically identify risk factors that may be unique to men. Particularly, a greater focus on male carers who are not biological fathers, and involving more demographically diverse groups, would significantly develop our understanding of what works in this space.

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