THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Fieldwork report:
National Review of Non-Accidental Injury in under 1s

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Background, scope and methodology

Background and scope of analysis

1. In March 2020, the national Child Safeguarding Practice Review Panel published their annual report for 2018-19, which included commitments for future work and learning priorities. The Panel's report stated: "We have been profoundly disturbed by the number of serious incidents involving the non-accidental injury of babies, often resulting in their death or life-long impairment. 27% of serious incidents notified and for which we have a rapid review, involved the non-accidental injury of a baby under 12 months old".

2. As a result, in April 2020 the Panel commissioned a national review of non-accidental injury in under 1s. This review included all serious incident notifications and rapid reviews received since June 2018 of cases that met the criteria.

Review questions

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)?

3. This is the 3rd national review commissioned by the national Child Safeguarding Practice Review Panel. One aspect of the methodology included the fieldwork analysis of cases notified to the Panel, which included undertaking deep dives into a sample of cases to identify themes and potential learning for the system arising from these cases. This report sets out the findings from this fieldwork.

Fieldwork and methodology

4. This review involved two Panel leads, a clinical psychologist and three reviewers from the national pool initially reviewing all rapid reviews notified to the Panel involving NAI in Under 1s over a two year period. Collectively, they identified an initial shortlist of 74 cases. These were further reviewed and resulted in a final shortlist of 23 cases in 19 local authority areas where it was felt there would be significant learning about the role of fathers/men. This further shortlisting process involved requests for further updates on the cases from safeguarding partners. The local authority areas in the final shortlist included County, Unitary,

Metropolitan and London boroughs and they were located in eight of the nine English regions.

5. In terms of approach, the three reviewers then allocated the cases between themselves and identified a dataset to capture initial key data. They then developed a further tool to capture and categorise this data from the rapid reviews which is reported in detail later in this report. They also wrote to each safeguarding partnership to set out the background and methodology of the review and requested this information be widely shared with partners and practitioners. In preparation for discussions with practitioners and statutory partners they developed two consistent agendas and designed a further template to categorise the key themes and learning.

6. The reviewers then contacted the safeguarding partnerships and had initial discussions to explain the process in more detail. This also included discussions on whether there might have been more recent cases that might best address the issue under review and some further negotiations resulted in the final cohort of 23 cases.

Practitioner and statutory partner engagement

7. The reviewers developed two consistent agendas, and following negotiations with safeguarding partnerships, virtual meetings were set up with practitioners and strategic partners. This resulted in the engagement of 171 multi-agency practitioners who met with reviewers to discuss the learning from the cases locally and nationally. These practitioners included midwives, health visitors, nursery staff, children's centre staff, hospital neo natal unit staff, GPs, early help workers, children's social workers, police and adult mental health practitioners. In one case, due to ongoing concern around the impact of the case, practitioners were asked to submit their responses to the questions from the reviewer in writing.

8. In addition, virtual meetings were undertaken between the reviewers and 151 senior strategic partners chosen by and representing the statutory partners. These strategic partners were identified by the local areas and the virtual meetings were held in each of the 19 local areas. These meetings included Directors of Children's Services (DCSs) and Assistant Directors/Heads of Safeguarding from Local Authorities; Designated Nurses and Doctors and Safeguarding leads from CCGs/Health Trusts and Police Heads of Public Protection as well as Partnership Managers.

9. The reviewers were highly impressed with the commitment of practitioners and strategic partners to contribute to the review at a time of immense pressure on services. This indicates the importance of this topic to those working with children and families and a strong desire to learn and improve practice.

10. Of the 23 cases in the cohort, 13 Serious Case Reviews (SCRs) /Local Child Safeguarding Practice Reviews (LCSPRs) had been undertaken/were being undertaken and the reviewers were able to read the draft reports and final reports. In addition, the reviewers had helpful conversations with a number of those independent reviewers to support their understanding and analysis. In one case the meeting with practitioners was done jointly by the SCR reviewer and the national reviewer to ensure a proportionate demand on practitioners.

Family engagement

11. Disappointingly and despite significant efforts by reviewers and practitioners in the local areas, there was a low level of engagement with families. This was primarily due to ongoing criminal proceedings. The reviewers did challenge some police forces on their positions to not allow reviewer's contact with parents and this was successfully overturned in one case. In another case the police allowed contact with the parents even though both were charged with murder and awaiting trial. However, unfortunately even in these cases the parents refused contact. Additionally, many of the cases were subject to ongoing or concluding care proceedings on the child and/or their siblings. Practitioners approached parents sensitively but most felt unable to contribute to the review. Reviewers did however speak with one mother and one maternal grandmother. The national reviewers were able to obtain the voice of families through the SCR / LCSPR processes where the authors of those reviews had met with the parents/family.

Headline data

Harm and male's relationship to child

1. In the cohort of 23 babies, 19 were seriously harmed and 4 died. Of the 4 babies who died, 4 suffered head injuries/trauma and in 3 cases they were found to have suffered additional fractures. In 1 of the cases, the death was thought to have been caused by injuries from a one off incident and in the other 3 cases there was evidence of historical injuries indicating injuries suffered on more than one occasion.

2. Of the 19 babies that were seriously harmed, 5 babies suffered head injuries/trauma with additional fractures; 3 babies suffered head injuries/trauma; 3 babies suffered fractures and bruising; 6 suffered fractures and 2 suffered from ruptured frenulum's.

3. Of the 19 babies who suffered serious harm, 5 babies were thought to have been injured as a one off incident; 10 babies suffered injuries on more than one occasion and in 4 of the cases it was not known.

4. Of the 19 babies who were seriously harmed, 5 babies are thought to be likely to suffer long term impairment, 9 babies were thought unlikely to suffer long term damage to their development and for 5 babies the prognosis was not known.

5. In 22 cases the men in this cohort were birth fathers and 1 was mother's partner.

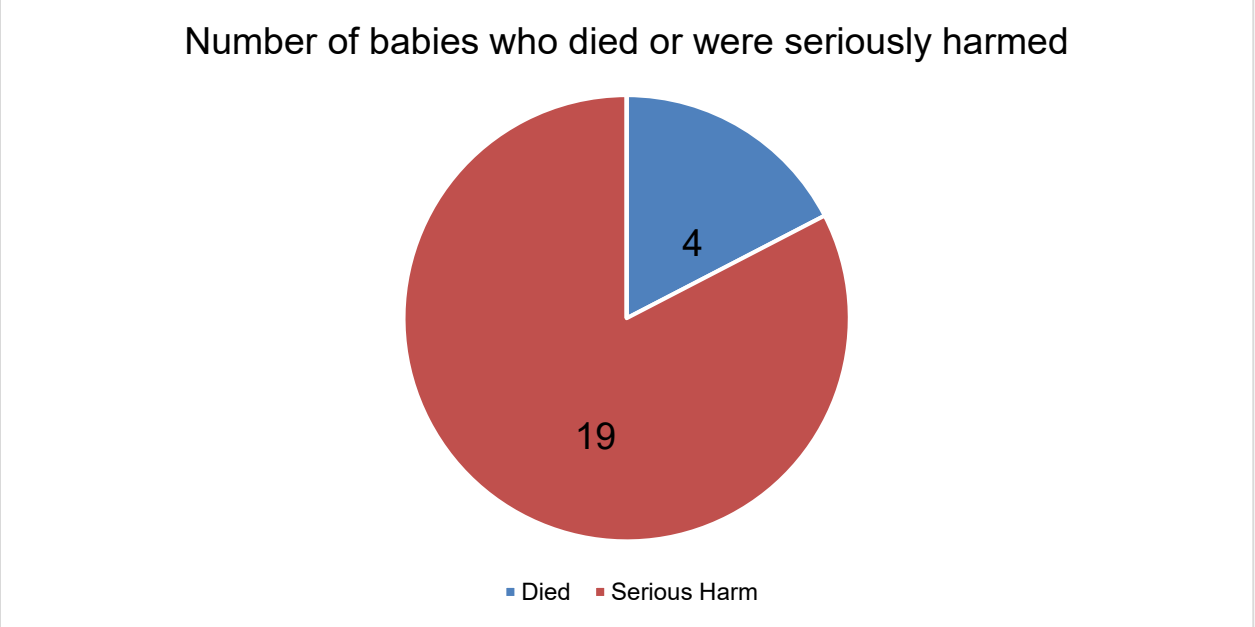

Figure 1: Pie chart depicting the number of babies in the study who died or were seriously harmed

Gender, ethnicity and age

6. Of the babies, 15 were male and 8 were female. Therefore, there were nearly twice as many male babies compared to female babies, which chimes with findings in the Literature Review.

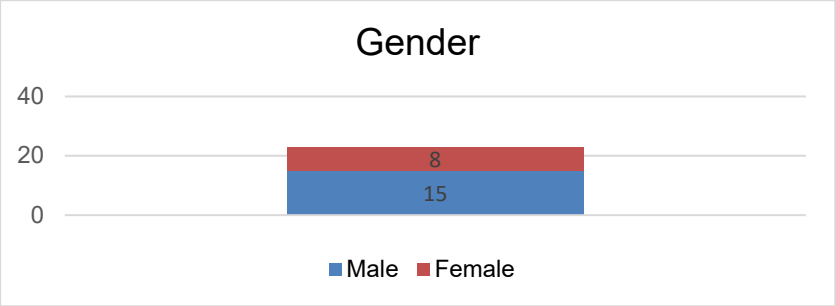

Figure 2: Bar chart depicting the gender of babies in the study who died or were seriously harmed

7. In terms of ethnicity, the majority were White British. 18 of the 23 babies were White British, 2 babies were White British/White European, 1 baby was Asian, 1 baby was Asian/Black Caribbean, and 1 baby was White British/Black Caribbean.

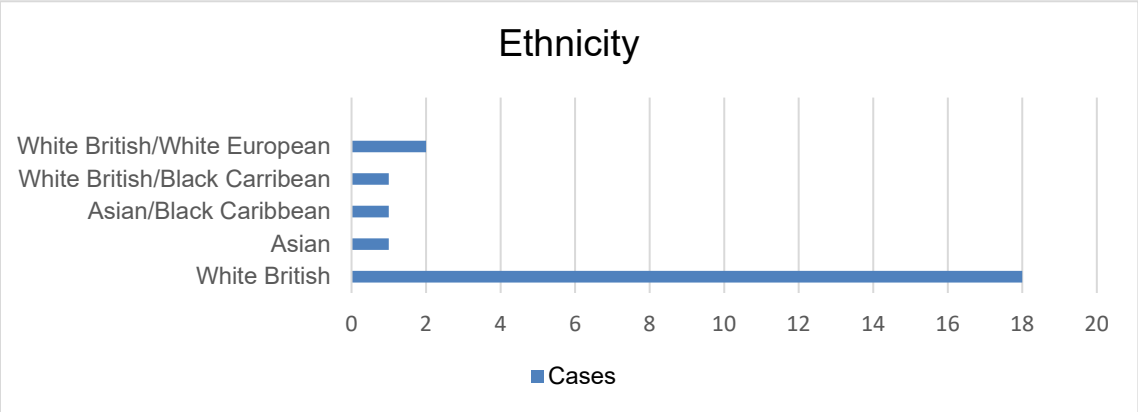

Figure 3: Bar chart depicting the ethnicity of babies in the study who died or were seriously harmed

8. It is perhaps significant to note that in 9 of the 23 cases the incidents of identified non accidental injury occurred around the age of 3 months. This was noted by practitioners to be an age where there can be peak crying levels by infants.

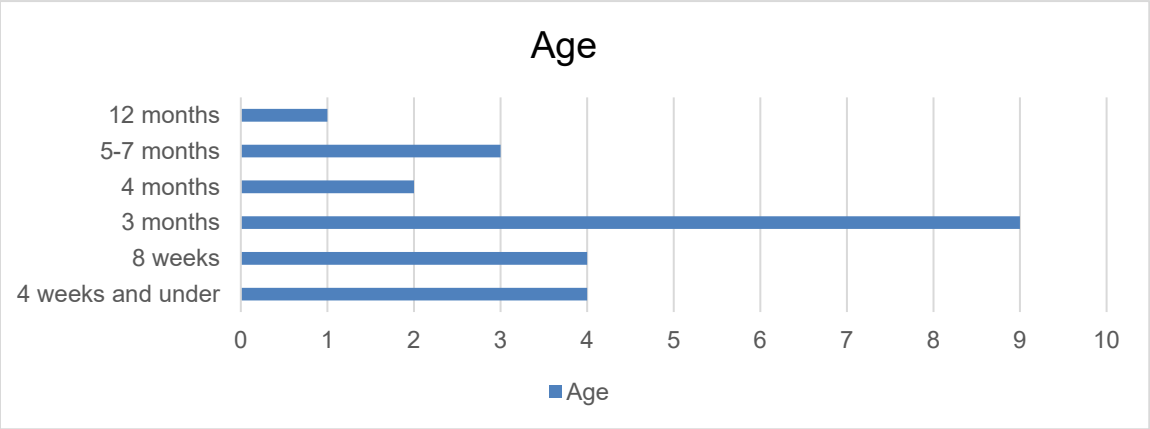

Figure 4: Bar chart depicting the age of babies in the study who died or were seriously harmed

Agency involvement, criminal proceedings and care proceedings

9. In the cohort of 23 cases at the point of the safeguarding incidents, 14 families were only known to Universal services, 3 families were known to Early Help services, 2 families were subject to a Child in Need Plan and 4 families were subject to Child Protection Plans.

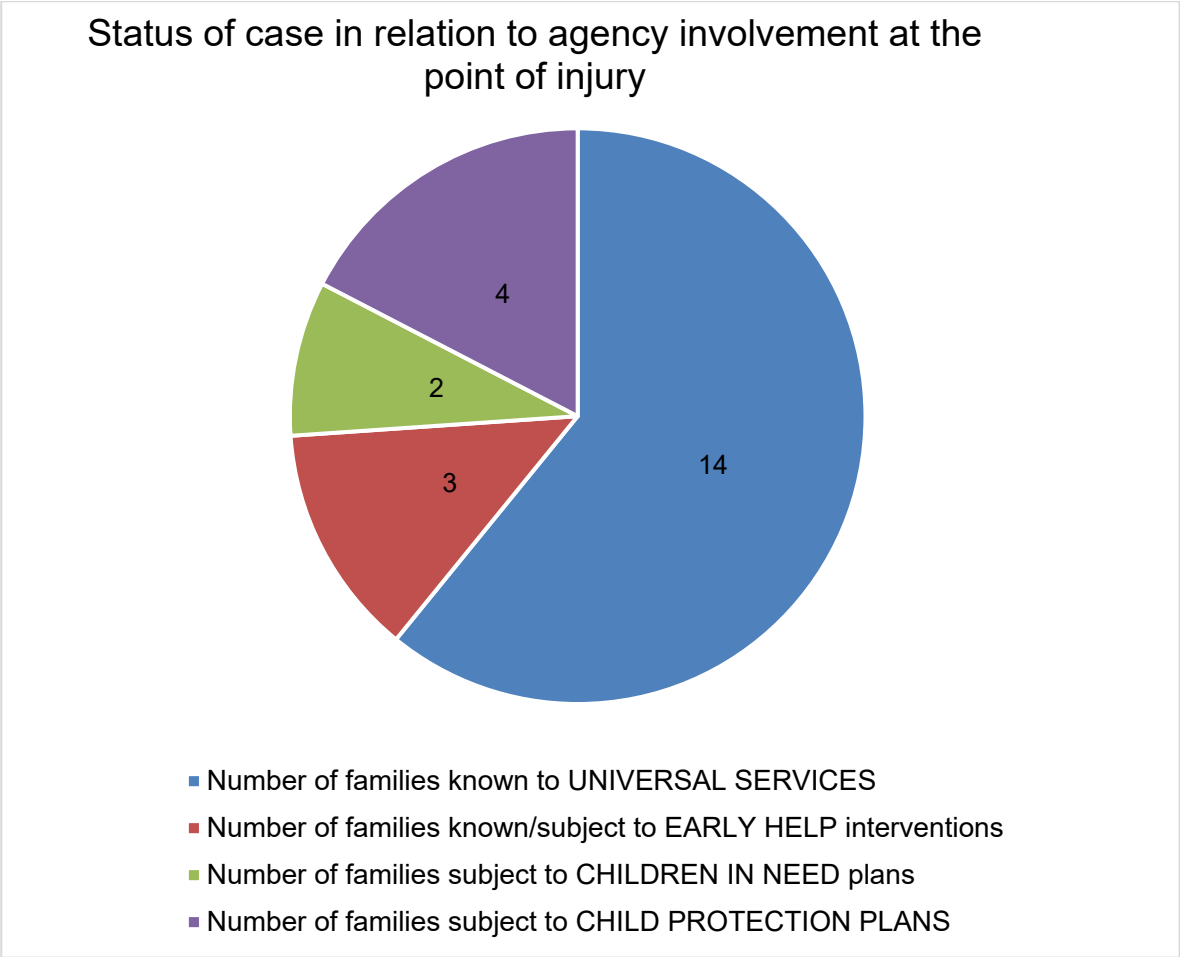

Figure 5: Pie chart depicting the status of the case in relation to agency involvement at the point of injury.

10. In criminal proceedings which followed after the incident, there were:

- 4 cases where father was the convicted perpetrator
- 4 cases where trials were ongoing. In 3 of the cases both parents were charged with the murder
- 8 cases where criminal proceedings were ongoing/awaiting CPS decision
- 7 cases where no charges had been brought against any individual.

11. In care proceedings which followed after the incident, there were:

- 5 cases where there were “Findings of Fact” against the father
- 4 cases against both the father and mother

Features of parents

12. In relation to the cohort of 23 cases, 10 cases involved issues of current domestic abuse involving current partners and 10 involved historical domestic abuse.

13. Additionally, 19 of the cases involved the mental health of either/both parents. This included histories of anxiety and depression, ADHD and anger management.

14. 4 cases involved parents where one/both were care leavers.

15. 9 cases involved cases where either/both parents were under 22 years old.

16. 9 cases involved fathers who had criminal convictions.

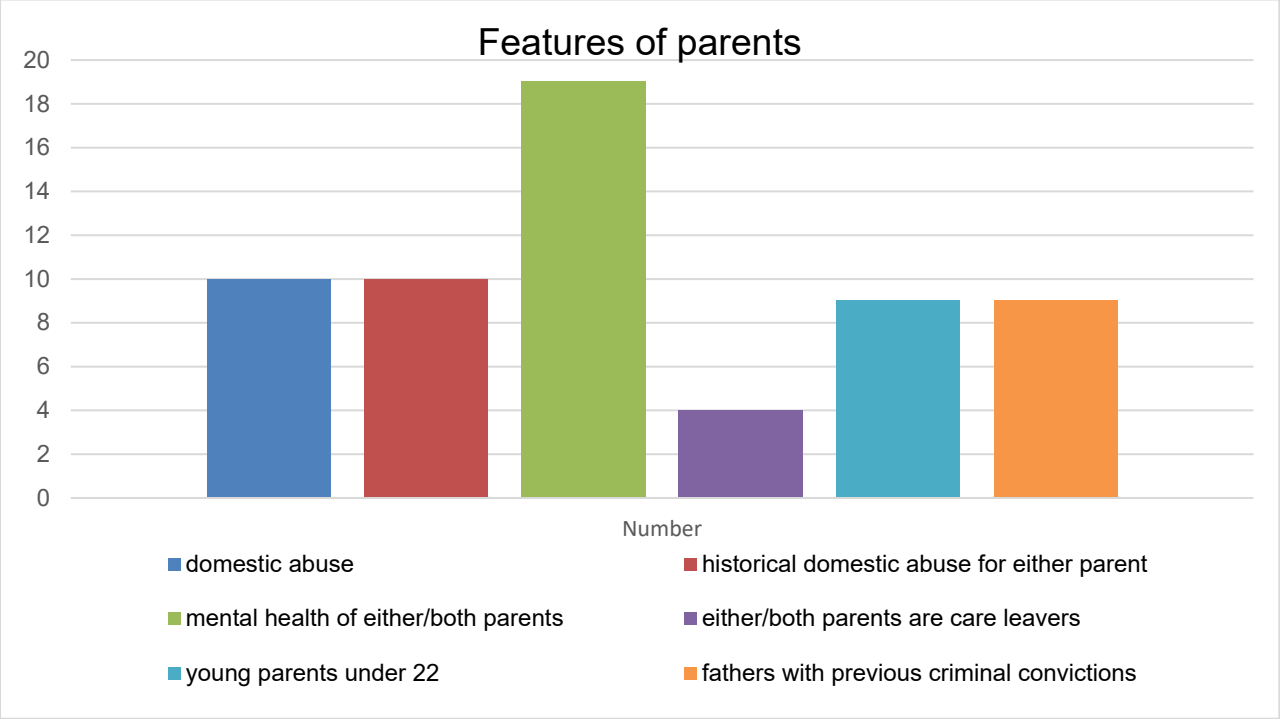

Figure 6: Bar chart depicting the features of parents for each case

Findings

Universal findings

1. Our overwhelming primary finding was that parenting is still viewed as the mother's role and responsibility by society and the services which support families through pregnancy and the first year of life. It was clear that overall antenatal and postnatal services are not commissioned for men or delivered to fathers/male carers.

2. As a result, fathers/male carers are not able to access the information/advice /guidance provided to mothers around the fragility of babies, the impact of young babies within the family and the needs of infants.

3. There was frequent concern raised by local areas over the capacity and unrealistic expectations experienced by midwives and health visitors to deliver health care and assess support/risk of men within families. In addition, many Family Nurse Partnership arrangements, whose remit is to work intensely with young families needing additional support have been decommissioned. They were only evident in 4 of the 19 areas in the cohort and were felt to be a significant loss in the support and identification of risk with young families who constituted 39% of the cohort.

Early Help

4. There was evidence that the step-down process from Children in Need (CIN) to Early Help is still not clear to practitioners/families. As a result, arrangements on how the case is to be managed under Early Help arrangements going forward were unclear, as was the identification of a key worker to coordinate the support plan. Often Early Help services are identified but there are no plans for how information will be shared or how progress will be monitored between agencies.

5. It was also evidenced that the issue of a parent's non engagement in any proposed "support programmes" in an Early Help plan was recognised as a barrier. However, it was frequently not considered or escalated as a potential risk factor.

Children in Need

6. There was evidence that those families with CIN status, despite reaching the threshold for Children's Social Care services, are not provided with the same level of resource/priority both by Children's Social Care and by all agencies. Other key agencies are not required to be involved i.e., GPs, which impacts on the quality of information sharing and decision making.

7. There was evidence that there was acceptance by professionals that if parents don't comply with the identified support "programmes" in the CIN plan there is little opportunity to "require" this and if there is no further incident the case is frequently closed.

8. It was also clear that information sharing was even more challenging i.e., CIN children are not "flagged" on A&E or GP or health systems. Multi-agency CIN meetings are less embedded in practice and there was evidence of less commitment and less focus and challenge.

Child Protection

9. There was evidence that the system frequently doesn't succeed in engaging fathers in the Child Protection Conference /Core Group process- this may be due to the men's work commitments or the need to undertake childcare to let mothers attend meetings. However, their engagement is not proactively facilitated. There also may be a potential perception by men, particularly by BAME men, that these processes involve practitioners who do not reflect them i.e., the workforce is predominantly female and often white.

10. It was also evident that Child Protection processes still do not routinely request engagement of GPs or housing services who often hold key information about families. GPs and their ability to engage in Child Protection Conferences remains a concern. This issue has been addressed and innovative solutions found in some areas but was a frequent issue in the fieldwork and the negative impact on information sharing/risk assessment is significant as GPs frequently receive key information.

11. It is also worth reiterating that any child being subject to a Child Protection Plan is not a protective factor in its own right.

Themes

Information sharing to assess/manage risk presented by men

1. It became very clear that information sharing, particularly in health, was presenting a real barrier to safeguarding children. Midwives and health visitors are the key practitioners to identify the possible need for support and risk within families. However, they frequently do not physically see fathers/male carers as fathers do not routinely attend antenatal classes or are present at postnatal visits. These practitioners cannot access any information on fathers as they do not have shared IT systems with other health functions and significantly most GPs require the consent of fathers to release their medical records.

2. There was evidence that the various IT systems used by midwives/hospitals/health visitors/GPs do not link /align and they operate in isolation. This impacts on practitioners working within these key health functions being informed of concerns. It is important to note that GPs may not know about the pregnancy of mother at all as much antenatal care is midwifery led.

3. There was evidence throughout the fieldwork that the impact of GDPR has made information sharing below S.47 level (child protection investigations) less effective. GDPR was described as a major barrier to safeguarding children because it limits the ability to use pre-birth protocols and procedures to trigger assessments due to the information on risk not being easily available to universal practitioners.

4. The reviewers also noted that IT systems in Children's Social Care do not always link /cross reference the names of men who may have had involvement with more than one family. Previous concerns with children in other households can therefore be missed.

5. Additionally, the transfer of information between health /housing services is not automatic if fathers move across borders/local authority areas.

6. There was also evidence of inconsistency in Multi-Agency Safeguarding Hubs (MASH) (Children's social care and partners 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. If there is a routine referral from police due to an incident where a child is present, MASH is likely to have an initial triage process which may mean further checks are not undertaken. There was evidence in one case that had police checks been carried out in MASH these may have provided information on previous domestic abuse allegations against both parents. From discussions with

practitioners, it appeared that thresholds to share information and to refer cases into MASH still appear unclear.

Access to universal services

7. The overwhelming evidence from this cohort of cases is that antenatal services are not sufficiently flexible. They are rarely provided out of hours/weekends and not proactively offered to fathers. As a result, fathers/male carers are not provided with the information or education provided to mothers on the needs and impact of infants within families, awareness of the impact of crying and how to feed and handle babies safely.

8. It was also evident that the capacity of universal services has reduced over recent years. Health visitors have 5 mandated contacts only: pre-birth, new birth, 8-week check, 1 year check and 2.5-year check. The impact of this reduction is the lack of time to develop trusting relationships with mothers and this becomes even more unlikely with fathers as at least 2 of these checks are often done in a clinic setting.

9. The health visitor antenatal pre-birth home visit is a potentially crucial contact when there is an opportunity to assess the needs of the family before the birth, but this can be missed if information of the pregnancy is not shared in timely manner or if the baby is premature.

Domestic abuse

10. Domestic abuse (DA) featured strongly in most of the cases in the fieldwork. They involved both current and historic DA and a small number of those engaging in abusive behaviour were women. Universal midwifery/health visiting ask “routine enquiry” questions on DA mandatorily to women. However, reviewers raised the issue of 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/controlling and when males may be present/interpreters are used. No midwives/health visitors were able to provide examples of positive responses to this question.

11. In addition, there was evidence of a “postcode lottery” of DA programmes commissioned by Local Authorities/Children’s Safeguarding Partnerships. Many of these programmes are spot purchased, and most programmes were not evaluated. Unless the baby is subject to a Child Protection Plan, there was frequently no follow up to ensure sustained engagement takes place or positive outcomes had been achieved. This clearly increases the risk to children.

12. It was apparent that Domestic Abuse Stalking and Harassment (DASH) assessments/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. It was suggested by a number of areas that some form of national system is required to track fathers who have previously had domestic abuse/violence convictions and then move in with other partners and their children. There was evidence within the cohort of repeat offenders who had not been recognised as presenting a risk despite past behaviours. It was also apparent that Clare's Law appears not widely understood by practitioners or promoted sufficiently to support mothers in understanding potential risk to their children and using the system.

Adult mental health

14. The term adult mental health is used in its broadest definition in this report. Many of the fathers/men in the fieldwork had a history of trauma/Adverse Childhood Experiences (ACEs) and have diagnosed Attention Deficit Hyperactivity Disorder (ADHD), anger management issues and anxiety and depression. As a result, many may have struggled to manage the emotional impact of caring for babies and the effect on themselves. This raises the question of how well the concept of emotional dysregulation is understood and responded to by practitioners.

15. Frequently it would appear men have had no therapeutic work to help them with their childhood trauma/behaviour. For example, they did not meet the eligibility criteria or "were not brought" to Child and Adult Mental Heath Services (CAMHs) appointments by their families. Therefore, agencies were left simply focusing on the presenting behavioural issues of adult men without addressing the underlying cause.

16. The following quote from a social work practitioner succinctly sets out this challenge to engagement:

    "Father was indeed very volatile and aggressive, and there has 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."

17. In the cohort of cases, very few of the fathers were engaged formally with adult mental health services and GPs were often the only agency that had this information on the fathers mental health needs. If they were involved, there was evidence that Adult Mental Health services struggled to focus on potential risk to

the child and remained concerned at the potential impact on the adult of loss of their trusting relationships. There was a suggestion from an adult psychiatrist to consider if a specialist advocacy service might be commissioned support men in that situation.

Policies and procedures

18. The reviewers identified key multi-agency policies and procedures that, when used appropriately, provide children with protection. There was evidence from the fieldwork that policies and procedures on bruising and marks in non-mobile infants are still not always followed by practitioners. The reviewers questioned if these procedures exist in every area and, if so, how they are monitored for adherence and impact.

19. In relation to procedures around pre-birth assessments, these were undertaken but the quality was variable, and they were frequently not multi-agency and often they did not provide background information on parents to inform the assessment of risk. In addition, and significantly, pre-birth assessments often did not involve the fathers.

20. “Was not brought” policies and procedures were also not always followed by health practitioners and do not always trigger referrals to Early Help/Children’s Social Care.

21. In 4 of the cases either or both parents were care leavers. This prompted discussion with local areas on whether this status should require mandatory pre-birth assessment in the “corporate grandparent” role to understand the support needed by carers in their parenting roles.

Invisible/non-engaged fathers

22. There was some evidence in the review that mothers may not disclose father’s details due to issues about housing tenancies and welfare benefits, and the potential impact of disclosure on family’s finances. Mothers may also simply not disclose father’s details or provide inaccurate information so checks cannot be made on background/history.

23. Although some fathers may have been in the property during visits by midwives and health visitors, not all were seen or proactively engaged since the focus of the visit was understood to be the welfare of the mother and baby. There were examples given of fathers not being named on caseloads with the message that the priority was to engage with the mother during any contact. An additional factor inhibiting contact with fathers was that they may not live with mothers full time and as a result they were often not included in assessments within universal services.

This was partly a capacity issue since there was no additional time allocated to engaging with the father of the child and partly linked to information sharing issues which are identified elsewhere in this report.

24. Where children were subject to Child Protection Plans, the review found evidence that the system meant fathers frequently aren't engaged in the processes around Child Protection Conferences /Core Groups. This may be due to work/childcare commitments and due to the potential perception that these processes don't engage men as generally practitioners are female professionals. However, in the small number of children in our cohort who were subject to Child Protection planning, there was evidence that practitioners were skilled in engaging with fathers.

25. As well as the need to ensure there is capacity in the system to include fathers, universal practitioners need to be supported by appropriate training, tools and supervision to develop skills to engage men and involve them in discussions. The development of confidence in working with men is particularly important in organisations which are primarily female focused such as some universal health services. The development of assessment tools and questions within supervision that explicitly encourage practitioners to ask relevant questions about the father of the child and reflect on any barriers that might prevent this, can inform a practice approach which normalises their involvement.

26. Practitioner skills and confidence are only part of the picture. Fieldwork discussions highlighted areas where fathers had been actively engaged, generally via male focused services in voluntary organisations and children's centres. It was noted that there had been a reduction in this type of provision and therefore the opportunity has been reduced for practitioners to work alongside fathers routinely.

27. In our cohort, nine men had previous convictions, however these were not all offences against the person. There were three cases where father was open to Probation and five cases where fathers were previously known to Probation. Practitioners however may not link a history of violence against adults as a potential risk to children and may not link programmes being undertaken by men as part of plans to protect children.

28. Transfer of information may cause invisibility. For example, if there is a "Finding of Fact" against the father in care proceedings, this information is often only known to Children's Social Care and if the father moves across a local authority boundary - this information can then be lost. The transfer of police information on father's/men's criminal backgrounds is only available if requested and the transfer of information between health /housing services is not automatic if fathers move across borders.

Additional features of cases found in the cohort

29. Several babies in the cohort had feeding difficulties or colic and cried excessively. There was limited evidence of work with parents to acknowledge the emotional impact and help them to manage possible frustration and anger. One serious case review helpfully commented:

    "[Practitioners can] medicalise crying by seeking to apportion a diagnosis such as colic or gastroesophageal reflux……there is a risk that this medicalisation focuses attention on treatment of symptoms rather than an exploration of the impact this has on parents and may distract from supporting them to manage their infant when crying."

30. How far antenatal programmes engage in discussions about the management of feeding problems and crying with both fathers and mothers, and the extent to which feeding problems may be understood as an additional risk factor, is an area for further consideration.

31. Weight loss in babies and older siblings was also a feature within this cohort as was prematurity in two of the cases. Practitioners were concerned that where babies are in hospital, fathers' non-involvement or lack of visits to Neo Natal Units due to work or childcare may have a negative impact on bonding and the relationship with their baby.

32. Nearly 40% of the cases in the cohort involved very young parents. In these cases, there were financial challenges and although they were noted there was little exploration of their impact, particularly in relation to the additional stress they place on the family.

33. Understanding each other's roles and responsibilities is an important aspect of safeguarding practice and within this cohort it was particularly evident that the role of the Personal Adviser for Care Leavers was not well understood by practitioners outside Children's Social Care. Personal advisors play an important role in supporting care leavers and their ability to form helpful relationships was clear. However, there was also evidence that assumptions were made about their role in identifying the potential risk to babies with a tendency to attribute a greater degree of responsibility for this to the personal advisor than should be the case.

34. A final additional feature of cases in the cohort was the extent to which practitioners described families as not unusual in the local area. This meant that in areas where there was a high level of known domestic abuse/violence and families struggling to cope it was hard to identify those babies who may be at particular risk of harm.

Impact of COVID-19, cultural competence and strategic leadership

Impact of COVID-19

1. This review was commissioned before the start of the pandemic and the majority of cases in the cohort involved incidents pre-March 2020. As the review progressed it was clear that this was an issue that merited further review. The reviewers were asked by the Panel to check with areas about the potential impact of COVID-19 on service delivery.

2. Most of the meetings between local areas and reviewers had taken place by the end of September 2019 and at that point a mixed picture was evidenced from practitioners/strategic partners. Some areas felt there had in fact been better engagement of men through virtual online contact in ante natal and CIN/CPP arrangements and this should be built on. Some areas however reported even mothers were not being seen antenatally and postnatally and there was concern at the potential impact on safeguarding.

3. There was a universal shared concern by all areas on the increased risk to new parents and babies during lockdown restrictions.

Cultural competence

4. The impact of ethnicity and culture on parenting was not overtly considered or evidenced in many of the cases and in some there was no reference to cultural background in case documentation. The overriding impression was that practitioners need more confidence to acknowledge and explore the impact of ethnicity and culture on parenting and that this needs to become an expected aspect of practice in all cases. There is absence of conversations with families about the way that culture impacts on them as parents and specifically on roles of fathers and mothers.

5. One case within the cohort prompted discussion about the safeguarding system's ability to engage with or challenge young black men when the workforce is perceived by young men as featuring predominantly white, middle-class women.

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.

Strategic leadership

7. The Panel asked reviewers to consider the impact of strategic leadership on practice. The evidence from discussions with strategic leaders was that the issue of how to work with and support fathers is recognised as important. In many areas safeguarding partnerships demonstrated that there had been thinking about how best this could be achieved, and some helpful services had been commissioned to support men, often with time limited funding. There was less evidence of any cohesive overarching strategies focused on how to engage fathers at all levels from policy to practice and across organisations. This resulted in a piecemeal approach and in some areas a disconnect between strategic leaders and their knowledge of some of the partner's commissioning intentions.

8. There was also some disconnect between strategic partners and their perceptions of operational realities/barriers. In more than one area practitioners reported more practice challenges than those discussed at a strategic level.

Conclusion and recommendations

1. This section contains conclusions and suggestions from reviewers and local areas on what might help to improve the current system to reduce risk.

Strategic leadership

2. The findings of this review indicate the importance of a whole system approach to practice change led nationally and by strategic partnerships. This whole system approach requires a cultural shift which acknowledges the important role that fathers play in child rearing and an expectation that at all stages and within all services they will be included in service developments and delivery.

3. There needs to be proactive targeted antenatal classes for men delivered flexibly and out of hours. Additionally, there is a need for targeted work with fathers who may have not accessed any antenatal educative programme. Alongside antenatal classes there should be promotion and commissioning/funding of nationally available online resources such as Dad's pad app /other online methods for men to access information.

4. The ICON programme is seen by practitioners as a helpful approach which should be evaluated and rolled out nationally using a whole system approach.

5. The standard 8-week post birth health visitor check should pro-actively include men and identify their needs.

6. A review of commissioning arrangements and funding to support 0-19 health services should focus on enabling capacity, flexibility and proactive engagement of men.

7. The training and supervision of practitioners in all agencies should empower them to engage with fathers and undertake challenging conversations.

8. Consideration needs to be given as to how midwives and health visitors can routinely access GP information on fathers without need for their consent.

Domestic abuse

9. There is a need for robust evaluated national Domestic Abuse programmes available in each local authority area for men (and women) who require timely access to targeted support to reduce risk of Domestic Abuse on adults but specifically against children.

10. Evidence of engagement and completion of these domestic abuse programmes which have reduced risk to be overt part of Early Help, Child in Need and Child Protection plans.

11. National government to consider establishing a “register” of men who have previous convictions for violence/assault against partners/children.

Adult mental health

12. Perinatal mental health services for men prior to and post birth should be developed in the same way as existing perinatal services for mothers. This should enable fathers to access mental health services/anger management or counselling as needed.

13. There needs to be proactive assessment by Adult Mental Health on the ability of men to parent when previous trauma/Adverse Childhood Experiences are known. This should be supported by the development of a specific risk assessment tool.

14. Further specialist training to be commissioned for Adult Mental Health practitioners on risks to children and how to address this with fathers/men. To include the consideration of an “advocacy “support service for men who are involved in both Adult Mental Health and Child Protection processes.

15. Further training/understanding for all practitioners in the system should be developed on the impact of emotional dysregulation.

16. The diagram below sets out elements of whole system change required to support improvement in the engaging, assessing and planning for and with men in the protection of children.

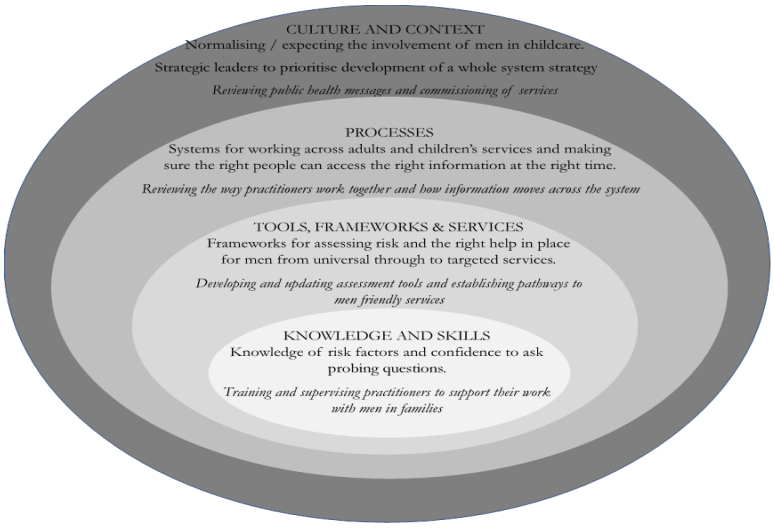

Figure 7: Diagram setting out elements of the whole system change required.

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