



7-minute briefings (7MB) are intended to be simple and quick to read, teams can use them within meetings as a team-based learning exercise.

## 7MB – The Myth of Invisible Men

[www.safeguardingchildreninstockport.org.uk](http://www.safeguardingchildreninstockport.org.uk)

### The Report

In September 2021 the Child Safeguarding Practice Review Panel published a report titled **“The Myth of Invisible Men” Safeguarding children under 1 from non-accidental injury caused by male carers’**. The review involved:

- Interviews with 9 male perpetrators currently serving prison sentences for harming babies
- A literature review
- In depth fieldwork research into cases involving 23 babies that have been notified to the panel
- Discussions with key stakeholders.

### The risk to the child from males

Men are between 2 and 15 times more likely than women to seriously injure or kill the under 1s.

Between 2000 and 2015 in England and Wales, 122 babies were killed by fathers.

**The greater prevalence of male abusers sits alongside a description of men as too often being ‘hidden’ or ‘invisible’ to safeguarding agencies**

### Links

To read the report in full, visit -

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1017944/The\\_myth\\_of\\_invisible\\_men\\_safeguarding\\_children\\_under\\_1\\_from\\_non-accidental\\_injury\\_caused\\_by\\_male\\_carers.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf)

### Improving Engagement

- Understating men's lives and their lived experience
- Engaging and assessing men – fathers histories should inform the development of parenting strategies to help fathers understand what good parenting looks like.
- Supervisions should focus on the involvement of fathers
- Service design addressing context and culture to allow involvement of fathers.

### Information Sharing

The report further highlight the need for communication and information sharing to allow practitioners to see and respond in a timely fashion to risk to babies. Key issues identified were:

- A lack of patient record integration within the health service.
- GDPR was seen by many to have made information sharing less effective
- Practitioners were unclear about thresholds for sharing information and referring cases to the MASH.

### Hidden Males

The report highlights how service design and practice tends to render fathers invisible and generally ‘out of sight’.

- “the man is not on my caseload” - health visitor
- Systems are often designed with a focus on the mother
- Men are often only partially seen
- Males ‘excluded’ from the work with families

### Themes

The review found that babies injuries often happened during a time of increased stress for the father, with the following themes noted :

- Men whose own parents were abusive.
- Men with histories of impulsive behaviour and low frustration thresholds– for example anger may have been present in childhood
- Men who abuse substances, especially drugs, which can lead to them having increased anxiety, stress, sleeplessness, and a reduction in tolerance, heightened impulsivity and poor decision making.
- Young fathers, including care leavers
- Men who use violence to mitigate difficulties including perpetrators of domestic abuse
- Men experiencing external factors such as poverty, racism, debt, worklessness or poor relationships with the mother of the child

In the context of the risk factors above, the father was often triggered to injure the baby as a result of normal infant behaviour such as crying or vomiting,

