

# **Psychologist report:** **National Review of** **Non-Accidental Injury** **in under 1s**

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# Introduction

## Background and scope of analysis

1. This part of the national Child Safeguarding Practice Review Panel's review looking into Non-Accidental Injury in children under the age of one focussed on interviewing men who had been convicted of perpetrating such injuries and who were prepared to talk to us about their experiences. An interview schedule was put together covering a wide range of topics, for example, exploring the men's backgrounds, their mental health and substance misuse histories, their relationship and forensic histories as well as their experience of any services they had been in contact with leading up to the injuries.
2. Clearly there were always going to be limitations in this part of the review as it was inherently a high-risk endeavour trying to get men to talk about their part in any child abuse: there were many cultural, psychological and emotional barriers that would have to be overcome before any of these men agreed to talk to us. As a consequence we ended up with a relatively small sample size of 9 cases with 8 actual interviews with men. It also has to be borne in mind that this was a self-selecting sample of men who agreed to be interviewed, each with their own specific reasons for consenting to do so. Their motivation for taking part was explored at the start of each interview.
3. The interviews with men did not start until deep into the overall project timescale. A number of logistical problems had to be overcome, for example, in terms of gaining research ethics approval and putting together appropriate consent forms. Also, once appropriate men within case reviews had been identified there were significant delays in identified cases actually going to Court: this meant criminal proceedings were unresolved and therefore it would not have been appropriate to interview these men and in some cases we were specifically discouraged from doing so by the police. In order to broaden the prospective pool of potential interviewees, the prison service was approached: an additional pool of convicted men, most of whom were still in custody, were then identified.
4. The admin staff on the Panel worked tirelessly to organise interviews with the men who consented to be seen but even then a number of practical problems arose. There were logistical issues trying to organise prison video calls and in some cases these were not available so the men had to be seen in person: not a simple task given this was in the middle of the Covid pandemic. There were numerous problems with the Panel interview scribes joining the video calls or being unable to hear what was being said. The interview facilities in prison were sometimes very poor, for example, there was a lack of privacy if conversations could potentially be overheard and this inhibited the men on two occasions. During one interview there

was drilling taking place next door which made it hard to hear what was being said. On more than one occasion the men were brought very late to the interview and so there was very limited interview time which in turn restricted the range of topics that were able to be covered. One man agreed to be interviewed but dropped out just days before it was due to take place: in this instance, as he had taken part in the Serious Case Review and had already been spoken to, this case was included in the project but it was a shame he was not seen. On another occasion the man involved had given his consent some weeks prior to the interview but no one within his prison had told him when it was taking place, and indeed he did not find out until the morning of the interview. Fortunately, in this instance the interview was conducted over two separate lengthy sessions and turned out to be one of the most informative of them all.

5. Within the interviews themselves further problems were encountered. Two of the men were mentally unwell (hearing voices, poor memory) and this obviously to some extent restricted the quality of the information obtained. Fortunately, the medical records were obtained for both of these men and in one instance these were far more informative than much of what he was able to report in person. The lack of any objective or background information was an issue in several cases so that it was difficult to corroborate what was being disclosed. This was particularly so where there was no Case Review or Serious Case Review and in some cases the only information available about the case was through media coverage, which is of course likely to be problematic in any case. It would have been extremely helpful to have all the men's medical records to corroborate what they were saying and in those cases where they were available, the information those records contained was extremely helpful and illuminating. In one case, the GP practice all but refused to hand the records over and were obstructive throughout even though the patient had given consent for those records to be accessed.
6. In three cases, the convicted perpetrators were still in denial, or else minimizing or not taking full responsibility for what had happened: one man continued to insist he had dropped the baby by accident even though he could not explain how this had happened; and in any case the injuries were so severe they were described at trial as similar to a 'car crash', which clearly bore no relation to what he was admitting to. Finally, it was entirely understandable that many of the men were reluctant to talk about what actually happened: they made it clear they found it too distressing to go into the details of the injuries so the final moments were not covered in any detail. It would simply have been unethical to insist on doing so and as one man put it, if he talked about what he did in detail he would have to go back to his cell thinking about this. It must of course be acknowledged that perpetrators of violent crimes can also be traumatised by what they have done. In my opinion however, the final triggers or moments are of far less importance than the overall context in which the non-accidental injuries took place.

7. On a much more positive note, several of the men engaged really well: they were open and honest about what happened and fully accepted responsibility for their part in the injuries and for the poor choices they had made leading up to their loss of control. Similarly, several of the men were there for all the right reasons: because they were genuinely remorseful over what they had done and they wanted to help to make a difference and hopefully prevent other children from suffering the same fate. In three instances the men were extremely grateful that they finally had a chance to tell their side of the story. Despite being involved in child protection proceedings, case reviews and lengthy criminal trials these men all felt that no one had ever asked them what had actually happened and their experiences had never been heard. This of course is relevant when we come to consider the issue of 'invisible fathers' as an emergent theme.

## **Theoretical perspectives**

8. It is helpful to consider some of the theoretical frameworks which helped inform the interview schedule that was put together and which also guided the thematic analysis of the interview transcripts. It was helpful to think about what is generally known about risk factors in violent crimes, for example, static and dynamic risk factors. In addition, the two main theoretical frameworks are based around Attachment theory well as the extensive research that has emerged from the Adverse Childhood Experiences (ACEs) literature.

## **Adverse Childhood Experiences**

9. Over recent years Adverse Childhood Experiences (ACEs) have increasingly been adopted as a theoretical framework for understanding adult problems and in the assessment of risk. The concept is coming under critical scrutiny and whilst there are without doubt some problems with the framework there are also many positives. One of the problems come from what is or is not included in the definition of an adverse childhood experience. There can be little argument that suffering physical or sexual abuse or growing up in a household in which domestic abuse or drug abuse is a significant problem are adverse childhood experiences, and there is a substantial body of literature which shows that these experiences have profound long-term consequences. Yet living in poverty or under substantial debt do not fit easily within the definition of an ACE, neither does for example, wider community based violence or anti-social behaviour. ACEs are therefore typically defined as occurring within households rather than, say, within a wider framework of social and cultural inequalities.
10. Another problem that arises with definition is that typically studies are based on participants' self-report: in my clinical experience often people do not define their experiences as abusive or adverse simply because that is all they have known

and they have nothing else to compare them to. Childhood neglect has serious long-term consequences but it is very difficult for anyone to look back into their childhoods and understand whether or not they suffered neglect; again it is all they knew.

11. The ACEs literature also ignores the contribution of protective factors, either within the family, the extended family or even through professional intervention, all of which might make a significant difference to outcomes even when there are ACEs present. It is however important to consider that when there are multiple, severe and repeated adverse childhood experiences, particularly involving childhood abuse, then protective factors no matter how substantial, are unlikely to make a significant difference: long-term problems into adulthood in such cases are highly likely to be severe. Finally, as the ACEs framework has become more widely adopted it is rightly criticised because it may be used in a way which is too simplistic or dogmatic and without critical thought or consideration of any complexities that may be involved.
12. Despite the problems or limitations in the ACEs approach, there are many positives. It is a very useful and simple framework for thinking about how the distant past affects current health and behaviour. It is often hard for both professionals and survivors themselves to think about how they might have been affected by events from the distant past, especially events that may have taken place decades ago. It is also a framework that places people's life experiences centre stage, as opposed to biological or genetic determinism which diminishes the contribution of people's lived personal, social, cultural and economic realities.
13. If adopted in too simplistic a manner, ACEs may be applied in a way that is too deterministic. ACEs are not deterministic factors in of themselves. They are risk factors when considered prospectively, following people's progress from childhood into adulthood, but they are causal factors when considered retrospectively, that is looking back into an adult's childhood experiences. Smoking is a risk factor that may lead to lung cancer but not all smokers get this disease: when faced with a patient with lung cancer who smoked then it is clear smoking was a factor that caused the cancer.
14. Many of the men interviewed had significant problems with substance misuse and with their mental health and many also had significant problems with anger: some of these men, though by no means all, also had problems with domestic abuse and interpersonal violence. The evidence base about the contribution of multiple adverse childhood experiences is clear, specifically in relation to substance misuse, mental health problems and interpersonal violence.

15. Hughes et al (2017)<sup>1</sup> searched five electronic databases for cross-sectional, case-control, or cohort studies published up to May 6th 2016, reporting risks of health outcomes consisting of substance use, sexual health, mental health, weight and physical exercise, violence, and physical health status and conditions, associated with multiple ACEs. Covering 253,719 participants across some 37 studies they found that:

16. Individuals with 4 ACEs were at increased risk of all health outcomes compared to individuals with no ACEs. The associations were as follows:

- weak or modest for physical inactivity, overweight or obesity, and diabetes
- moderate for smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease
- strong for sexual risk taking, mental ill health and problematic alcohol use
- strongest for problematic drug use and interpersonal and self-directed violence

17. In the Welsh ACE Study (Bellis et al (2016)<sup>2</sup>, 4000 people aged 18-69 were approached; 6 in 10 who were asked agreed to be interviewed. They found that:

- 52% reported no ACEs,
- 47% reported just 1 ACE,
- 16% reported 2-3 ACEs and
- 14% reported 4 ACEs.

The study also found that individuals with 4 ACEs v. individuals with no ACEs:

- 2 x binge drink and have a poor diet
- 3 x current smoker
- 7 x involved in violence
- 11 x used illicit drugs
- 11 x incarcerated
- 15 x more likely to have committed violence in last 12 months

18. As will become apparent in the emerging themes from the interviews below, it is important to consider the implications for any intervention or treatment for those who have suffered extreme adversity in childhood. When we are looking at those who have suffered repeated, multiple childhood abuse and trauma over a long period of time then the limitations of any intervention or treatment have to be realistically appraised. For these men and women, we are typically looking at what

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<sup>1</sup> The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis, Lancet Public Health (2017) Aug;2(8):e356-e366 [<https://pubmed.ncbi.nlm.nih.gov/29253477/>]

<sup>2</sup> Bellis MA, Ashton K, Hughes K et al. (2016). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Cardiff: Public Health Wales / Liverpool: Centre for Public Health, Liverpool John Moores University

are likely to be limited internal changes and therefore need to think more about external monitoring or containment, risk management rather than therapy or treatment. We are also likely to have to think about a systems approach not just individual intervention; managing risk through multi-agency working rather than expecting individual treatment to have a significant impact on any risk reduction.

## **Attachment theory**

19. Another theoretical framework which has emerged as particularly helpful is that of Attachment theory. This is particularly so as so many of the men interviewed had significant attachment problems and this is also a finding in previous research looking into the same offences. 'Attachment' reflects the quality of the relationship or 'bond' between a child and his or her caregivers. Attachment is divided into secure and insecure. Insecure attachment is further differentiated into three separate categories:

- anxious/preoccupied; this presents as hypersensitive, rejecting and attention seeking
- avoiding/dismissing; this presents as hypo (decreased) sensitive and isolated
- unresolved/disorganised; this presents with a paucity of coping systems, pervasive affective dysregulation and is alternating clingy, rejecting, and fearful of the caregiver.

20. Insecure attachments occur during childhood when there is abuse or trauma, and when the caregiver is seen as dangerous, harmful, unpredictable, rejecting, cold or inconsistent. This results in confused relationships with caregivers, and is then transferred by extension to other relationships as the child grows and develops. The consequence of insecure childhood attachments are profound: as an adult this typically results in a poor sense of identity and by extension a poor sense of self in relation to others. Disturbed, chaotic and disorganised relationships feature prominently as adults.

21. Importantly, disturbed attachments as parents are likely to feature in the quality and nature of the relationship with their own children or any children in their care. Unresolved attachment needs as a parent often develop in the context of a parent-child relationship whereby the child's vulnerability or expression of need (e.g. being upset, tired, hungry, angry) inadvertently activates the parent's own dysfunctional attachment system. In this state, the parent is unable to recognize or attend to the child's needs, instead they respond to or are overwhelmed by their own feelings or distress or say, anger. This is important for thinking about what happens in the moments when the child is being injured.

22. Finally, it is helpful when considering risk factors to think about the following:



- The Past
- The Present/context
- Circumstance
- Chance

23. A perpetrator's past is often relevant especially when we are considering the contribution of historical childhood abuse, especially when that abuse is severe. We also need to think about other forms of trauma that the perpetrator may have suffered, for example, the early loss of a parent or being removed from harmful parental care. As they cannot be altered these are of course considered static risk factors. Further static factors might be the person's forensic history, for example, whether or not they are known to have previously perpetrated domestic abuse or other violent crimes.

24. When we consider the present or context in which violence takes place, we need to think about factors from the much more recent past or the present context, often these are dynamic risk factors as they are open to change: for example, whether the relationship with the mother of the injured child was a destructive one or not would be relevant here, as would the circumstances under which the child was conceived. At risk of stating the obvious, a child that is wanted and planned for enters a very different world to one in which it was conceived through impulsive unprotected sex with parents who are ambivalent about their relationship and about becoming parents. The perpetrator may well have a history of mental health or substance misuse problems, which are both dynamic factors in as much as they can be an on-going issue or not, that is, a continued problem or else for example, treated and in remission. So whether the perpetrator had continued to abuse drugs in the weeks and months leading up to the injuries would therefore be a relevant contextual factor. Continued debts and the stress this may give rise to would be another example of a contextual and dynamic risk factor.

25. When we come to consider 'circumstance' we need to think about what actually happened on the day or night of the injuries that altered the course of events. Had the perpetrator slept the night before, had they been taking drugs or drinking when they had the child in their care? Had they for example, been troubled by hearing voices or was their mood particularly low that day? Had they had an argument or been fighting with the mother that day so that they were in a heightened emotional state when the injuries were inflicted? In one instance in our interviews, the man who killed his son was supposed to take the older children to school that morning: instead, having been up all night playing video games, he decided to stay at home with the infant so that he could continue taking drugs.

26. Finally we have to consider the part that 'chance' plays: a man can stab another adult fifty times and because they survive they are only convicted of Grievous Bodily Harm and yet, on another occasion the victim could be stabbed once in the wrong place and die. What struck me listening to the men and reviewing these and other similar cases I have been involved in, was that the unique feature of non-accidental injuries to infants is the fragility of the children involved: so that in other situations when these men might become frustrated and angry, the consequences are highly unlikely to be so grave.
27. What became clear from the interviews was that the inflicted injuries often occurred within a context of historical as well as more recent stresses: typically a combination of historical adverse childhood experiences or childhood abuse as well as significant problems in the days, weeks and months leading up to the actual NAI. Significant relationship problems were common, within a spiralling negative cycle of drug abuse, deteriorations in mental state and poor decision making, and a lowering of what was for many an already low frustration threshold. The injuries inflicted were in response to normal infant behaviour (e.g. crying, being sick) but that behaviour was only a trigger in the context of all the other stresses that were contributing up until that moment in time: the 'straw that broke the camel's back'.
28. One man's violence and anger started as a teenager soon after he suffered sexual abuse by an older woman who encouraged and facilitated his early drug and alcohol abuse. In many ways the destructive relationship with the mother of his children mirrored that earlier abusive relationship and this pushed him even further into drug abuse and far beyond his already limited ability to cope.
29. Some had no apparent significant past. One man recalled a good home life with no problems – his parents were together all the way through his childhood: "I couldn't ask for better parents". So whilst in his case there was no obvious childhood abuse or trauma, he was still living with his parents into his forties and he had never had an adult relationship before meeting the mother of his children: this is all indicative of significant attachment problems as well as low self-esteem. His first relationship was with a very young female who had her own history of multiple adversity in childhood and significant mental health problems. His low self-esteem, the pressure of mounting debts and a very destructive relationship with the mother of the child pushed him beyond his already limited coping skills. His sense of shame about the situation he found himself in prevented him from speaking out or seeking any help.

## Headline data

### Victims

1. The cases which were considered for this part of the review involved the following:
  - 6 boys
  - 3 girls, 1 of whom was a grand-daughter
  - 3 sets of male twins (one twin was injured at a different time to the index victim, in another case both twins were injured at the same time, in another case only one twin was injured).
  - 8 infants died
  - 1 girl was left with serious permanent disabilities
2. None of the cases involved step-children. In one case the child that died was fathered by another man whilst mother was in a relationship and living with the perpetrator, who already had older children by her. The man did not know he was not the father until sometime after the child was born but he insisted this made no difference to him and he treated the child as his own.

### Final triggers

3. The known final triggers were:
  - 2 crying
  - 1 vomiting
  - 1 breathing difficulties
4. The final trigger was not known in the other cases as the men were either in denial and in one case not telling the truth: as mentioned already, in many cases the men were simply unable or unwilling to go into that much detail. Also as noted above, the final trigger is in my opinion far less significant than everything else that has to be taken into consideration.

### Men interviewed

5. There were eight interviews:
  - 9 cases (one man took part in the SCR but dropped out of our interview just days before it had been arranged: as noted above, as he had been spoken to in detail within the SCR since the NAI this case was included).
  - None of the men were teenagers at the time of the NAI: many were in their 20s, two were over 40.
  - 6 were white British, 1 mixed race (black Caribbean/white), 1 Portuguese, 1 Polish
  - 1 was a care leaver, 1 was placed with relatives as a very young child

## **Mental health problems**

6. The known mental health problems amongst the men interviewed were:
- 7 of the 9 men clearly had low self-esteem: it was not entirely clear in the other two.
  - 1 hearing voices, anxiety, depression
  - 1 psychosis (voices, delusions, paranoia)
  - 2 depression and anxiety
  - 4 Clear PTSD / trauma issues
  - 1 of the men had no history of any obvious MH problems (but he did have significant anger problems and extremely low self-esteem)

## **Adverse Childhood Experiences**

7. Among the men interviewed:
- 3 significant multiple ACEs
  - 4 some ACEs
  - 1 not known
  - 1 unclear

## **Attachments**

8. Among the men interviewed:
- 7 cases involved significant disturbances in attachments as children
  - 1 not known
  - 1 not clear

## **Substance misuse**

9. Among the men interviewed:
- 3 had no history of any drug or alcohol abuse
  - 6 multiple drugs and/or alcohol
  - 6 Cannabis – chronic use (i.e., long standing), all of whom started smoking this drug in childhood.

## **Anger or violence issues**

10. Among the men interviewed:
- 7 of the 9 men had problems with anger and a low frustration threshold (of the remaining two it is not known whether one of them did or not).
  - 3 had previous convictions for violence

- 5 cases involved domestic abuse: 1 of the men was a victim, 1 of them was a victim as well as a perpetrator
- 6 Cannabis – chronic use (i.e., long standing), all of whom started smoking this drug in childhood.

11. Previous convictions for violence were not a prominent feature though some of this violence went undetected (for example, street fights that never get reported).

## **Debt**

12. Among the men interviewed:

- 4 experienced significant debt
- 3 of these were with heavy drug users

## Emerging themes

### Male victims

1. A literature review as part of this review found that “The most consistent and well evidenced finding from this set of studies is that sons have been more prevalent than daughters among victims of father-perpetrated NAI”.
2. 2 out of 3 are male victims in this study and this figure seems to be generally representative in previous studies. Clearly with such a small sample size there is not too much to be made of this finding, but it is interesting that the ratio was similar to the general data looking into this area.

### Previous study by Dickens (2018)

3. A previous study looking into men who have perpetrated injuries or who have killed children in their care was carried out by Dickens (2018) (quantitative and qualitative data from a small-scale UK study interviewing convicted perpetrators). What was striking was that there were many similarities between the findings in that study and the information gathered during these interviews. Dickens found that there were marked differences between men who were generally violent including towards their partners and those who were only known to have perpetrated severe physical abuse of a child:

“Convicted father perpetrators of severe physical abuse of their young child (without a conviction for associated partner violence) have lower self-esteem, anxious attachment styles and disengaged coping strategies; victim empathy, and moral justification of not using physical discipline, yet poorer knowledge of appropriate parenting strategies and age-appropriate child behaviour, compared to convicted male perpetrators of violence to other men – this suggests that anger, insecure attachment issues, misinterpretation of their child’s behaviour, feelings of rejection by their child, and situation-specific issues override victim empathy at the time of the father’s physical child abuse. Yet the child abuse does not appear to be solely ‘parenting gone wrong’ – the child harmers and the adult harmers in this study shared high prevalence of drug use, poor emotional control, heightened anger responses and avoidant attachment styles”.

“Discriminant analysis supports the most important differences between groups [adult harmers and child harmers] were empathy to children, anxious attachment style, coping responses to stress, suspicious thinking in cognitive anger responses and their self-esteem.

The child harmers in this study demonstrated significantly higher levels of empathy for their victims compared with adult harmers. This suggests that at the time of the

offence child harmers may have experienced a deficit in the empathetic process or that other factors, such as arousal, poor emotional control, insecure attachment and anger control impacted on the empathetic process".

## **Anger and low frustration threshold**

4. As can be seen from the Dickens study, the defining differences between those men who were violent to adults as opposed to those who had only harmed children was their poor anger and emotional control (particularly at the time of the offence), their poor attachments, their low self-esteem and their limited coping skills. In these interviews with men, a very common theme that emerged was poor emotional regulation, poor anger control (often since childhood) and a low frustration threshold. Some of the men may have been violent generally but in many cases their violence was only specifically in relation to their infant victims. Many of the men reported problems with anger and regulating their emotions since childhood, so that histories of throwing objects, smashing objects, punching walls or kicking doors were common. A number of men had attended A&E with injuries from punching walls and some reported becoming increasingly angry and frustrated in the weeks and months leading up to the NAI. Other examples of impulsive behaviour may also include impulsive overdoses or other forms of self-harm. It is clear that coping with frustration and expressing outbursts of emotional or behavioural anger was common for many of the men, even if they were not violent or domestically abusive. It is therefore a very thin line between throwing or lashing out at an inanimate object where the consequences are very limited, to behaving in the same way towards a fragile infant when the consequences are likely to be fatal.
5. It is far easier and far more common for child protection agencies to focus on men who are known to be violent or who have extensive forensic histories including for domestic abuse. Focussing on the potential harm from these men is of course merited. However, the findings from this and the Dickens study indicate that there is another group of men, who are arguably harder to identify, that have anger problems and a low frustration threshold and who do not cope well with stress. Some of these men may well have been seen for significant anger problems as children and there might be evidence of this in their medical records. If these risk factors are identified, for example, through hand injuries or self-report in medical or other records, then this has to be taken very seriously if the men are caring for a young child.

## **Invisible fathers**

6. One of the striking findings in the interviews was that these men as fathers had rarely been included in any universal services, they had rarely been seen and were even less likely to have been heard. Despite a range of universal healthcare

services including midwives and health visitors, and even in two cases where there were significant concerns about DA, none of these men had been spoken to on their own prior to the NAI. Universal services focus almost exclusively on prospective mothers and fathers are simply not involved in anything other than a marginal way.

7. Two of the men may well have opened up to professionals had they been given the opportunity to do so. One father stated:

“Every time the HV and SWs visited a pretty picture was painted by [Mother] and I stayed silent and imagine me sitting there thinking ‘what a croc of shit’. I often thought about following the professional out and telling them that everything is false...as soon as she left the house it was tantrums and chaos again. The people coming in our home never really knew how horrible the household was”.

8. What was just as striking was that even when a case review or a serious case review had been conducted and the men interviewed as part of that process, the quality of the information gained was extremely limited and so much detail was simply missing. In one of the interview cases, the father’s chronic substance misuse history had been a daily problem for over two decades and was a major contributory factor in the fatal NAI. Yet in the Serious Case Review in which father had agreed to take part, the only mention of any drug abuse was from the mother who mentioned it in passing: this was literally the only mention of this in the review. In another case, the man clearly had a history of significant drug induced psychosis which included delusions, hallucinations and ideas of reference (believing insignificant or random events were specifically directed at him). This was clearly a factor in his child’s life-changing injuries and yet the serious case review and practitioners in the case had failed to identify that the man had been that mentally unwell.
9. Perhaps just as striking was that as a result of the NAI, several of the men had been involved in lengthy childcare and criminal proceedings. Yet even within those proceedings, the men had not been heard. Three of the men were effusive in their gratitude for finally being given a chance to tell their stories in these interviews, to be heard, to have their realities acknowledged.
10. And emerging from the detailed and honest accounts the men disclosed were complexities that case reviews, childcare and criminal proceedings had simply not revealed. One of these men had been the victim of significant domestic abuse; another had been both perpetrator and victim and arguably more of a victim. Some of the men were clear that they were only responsible for some of the injuries (typically the fatal ones) but insisted they had not caused others that had been found. Too often men are viewed in simplistic dichotomies: good/bad, risk/protective, domestic abuser/supportive. Such binary thinking means that



practitioners may struggle to discover or evaluate the complexities that were found when talking to these men.

11. The need actually to talk to men who are prospective or new fathers was clearly an emergent theme. This means that universal services need to ‘think family’, and a whole family holistic approach to assessing any vulnerabilities or risk factors in both parents is required. In too many cases there was a lack of professional curiosity about the fathers even when significant concerns were raised or known about them. Perhaps we need to replace the notion of professional curiosity with notions of due process or due diligence, in which fathers of pregnant women should be included in any assessments. Imagine a world in which it would be negligent not to meet with, talk to or assess prospective or new fathers. As such, any local or regional examples of good inclusive practices need to be evaluated and disseminated so that these men as fathers are seen and heard, particularly where any concerns have been identified.

## **Information sharing between adult and children’s services**

12. Within the interviews and reviews of cases, another theme that emerged was the failure of adult services to communicate and share information with child-oriented services. Where there are identified risks about men, when they become fathers these risks are still not being disseminated to other agencies: there was a lack of joined up thinking even when significant risks had been identified. A striking example is in the case which we will refer to as involving father AB:

In 2013 it was identified that AB was:

“A potential risk to others when under the influence of drugs” and a  
“potential risk to others when under the influence of drugs and this is having a major impact on his current presentation and behaviour” and  
“a risk to others as ‘consequences of impulsivity’”.

13. Many of the risk factors that emerged in these interviews were present in AB’s recent history. He had long history of cannabis abuse, a long-standing problem with managing his anger and being short-tempered and as recently as January and September 2018 he was having aggressive and at times violent outbursts. The child involved died just months later in the Summer of 2019.
14. Father AB was mentally unwell: he had been hearing voices telling him to harm others, he had chronic sleep disturbance and continued to smoke cannabis. His compliance with any prescribed medication was poor and his engagement with mental health services very erratic. The information about his risk was there and well documented in his medical records and yet, none of this was communicated with children’s services when he became a prospective and then new father.

15. Could there be some sort of flagging/warning system in place so should men with such a risk become a father then Health Services and other agencies are alerted?
16. The same case with father AB highlighted the continued problem with information sharing more widely that became obvious when reviewing these cases.

The mother of AB's child was well known to Children's Services since 2007. The Early Help Multi Agency Team (Mat) was involved for a period of several months but this intervention ended not long before the baby died.

Mother had significant known vulnerabilities including a recent history of Domestic Abuse, Mental Health problems and a possible learning disability. Despite her history and various concerns about her parenting, when she fell pregnant by AB no detailed information about him in relation to safeguarding was gathered and indeed, little seems to have been known about him.

17. The Rapid Review Report highlighted several issues: the MAT assessment made reference to Mother having a new partner but no checks were made; during antenatal appointments issues were identified in relation to father AB's mental health and concerns were raised, yet this was not followed up; GP records show that AB was discussed more than once at the GP safeguarding meeting but this did not result in a referral to Children's Services or indeed any other agency.. As stated, this was not a case in which father's potential risks were not known or could not have been predicted: father's risks had been identified and were well known in the years and indeed months prior to the fatal NAI.
18. This was one of several cases in which the men were interviewed that highlighted another theme that also repeatedly emerged when practitioners were interviewed as part of the Panel's wider review. There is potentially so much important information about risk within GP records but gaining access to that information was often very difficult, even for other healthcare practitioners such as midwives and health visitors. There seems to be widespread confusion about when GP records can or cannot be disclosed and considerable discrepancies across the country in terms of how or when that information is shared. Lowering the threshold at which GP records are made available, or having a medical database that is shared amongst healthcare professionals, would definitely facilitate information sharing and thereby improve the safeguarding of children.
19. The case of AB identifies another emergent theme:

## **Vulnerable mothers**

20. The mother in the AB case had numerous significant vulnerabilities. She had not long left an abusive relationship. Despite her history and vulnerabilities, no information was sought about AB when she fell pregnant by him. In such cases where there are vulnerable mothers who have been in known abusive relationships and especially those who have a known history of ACEs or MH problems or substance misuse, these women are highly likely to form further harmful relationships or abusive relationships. It therefore makes sense that in such cases the partners of these women should be routinely screened for any potential risk factors.

## **Information sharing about drug misuse**

21. Many years of routine/daily cannabis use was a significant contributory factor in many of the cases, whether or not other drugs or alcohol were also abused. Many of the men had been smoking cannabis since childhood, in one case he had started before the age of 10. As noted, in several cases drugs were not considered or identified as a risk factor by professionals working with the family and barely mentioned even in SCRs.

22. Perhaps because its use is relatively widespread there seems to be a tendency to minimise the detrimental impact this drug has. Cannabis cannot be considered a safe recreational drug. Modern cannabis in the form of weed or 'skunk' is highly potent drug and can be very toxic: that toxicity is not just in terms of drug induced psychosis but because of an overall negative impact on many users' emotional and psychological wellbeing.

23. In one of the cases, none of the practitioners working with the family had identified that in the months leading up to the fatal NAI, the parents' cannabis habit was hundreds of pounds a week and this in turn had led to significant debt. By the time the child was injured and died, the conditions at the family home were extremely poor. In the months leading up to the fatal NAI, Police had been to the house twice because neighbours had complained about the smell of cannabis, but this information was never shared with other agencies.

24. In that particular Serious Case Review, the issue of significant cannabis abuse was raised and practitioners noted that it was difficult to differentiate or screen for cannabis use as a risk factor because "so many families we see use cannabis..."

25. The contribution of drug abuse, and cannabis in particular, as a significant risk factor in many of these cases cannot be ignored. If cannabis or other substance use is known or suspected then medical background checks should be made: cannabis use is contraindicated in anyone with a history of significant mental

health problems, with known ACEs and particularly where there is any history of mood or personality disorder including a history of impulsive anger or violence or a low frustration threshold. As noted, the fathers may well have reported problems with anger and frustration to their GP's and there may well be evidence of them losing their tempers in ways that have already been identified: for example, punching walls, throwing objects, hitting oneself, or self-harm through impulsive actions.

26. Substance misuse must therefore be pursued as a risk issue because if there are other problems then that substance issue is highly likely to make any of those other problems far worse. In one case (father ZX), cannabis was smelt at the house but denied by the parents. There was little or no mention by professionals of parental drug use and it barely got mentioned in the SCR even though it was a massive contributory risk factor. If drugs are known or suspected, this should be enough to trigger a disclosure of GP records so that any other issues can then be identified or ruled out.
27. In the ZX case there were significant concerns about domestic abuse and father was a known repeat DA offender. Father told various GPs he was struggling with anger issues in the months and weeks leading up to the NAI and he presented as stressed, irritable, panicky and crying: he was clearly not coping at all well. He also told his Probation Officer he was not coping. ZX disclosed at interview that he had a significant daily cannabis problem over two decades (he also abused other drugs and alcohol) as well as issues with his anger since childhood which were also well documented in his medical records.

## **The combination of substance misuse, mental health and domestic abuse**

28. The notion of the so called 'toxic trio', involving parents with mental health, substance abuse and domestic abuse problems is well established. There are problems with a simplified assessment of these factors and clearly there is more work to be done to establish how these risk factors lead to children being harmed. These interviews with men highlight that whatever the shortcomings of the notion of a toxic trio, these are all risk factors that cannot be ignored. And, as noted above, these are all adult problems that are highly linked to multiple adverse childhood experiences.
29. In many of the cases where the men were interviewed, there was a negative cycle in these men's lives: many had histories of multiple or significant ACEs, poor attachment histories, limited coping skills, and problems with anger and a low frustration tolerance. These men typically turned to substance misuse as a

maladaptive coping strategy, as a way of trying to manage their emotions or anger, to self-medicate for mental health problems or to try to diminish the impact of traumatic thoughts and feelings. Unfortunately, the more they used drugs and/or alcohol, the worse their impulsivity and volatility became. Their mental health and/or mental state then deteriorated even further: this then led to poor decision making, even worse emotional and behavioural regulation, significant relationship problems and ultimately to increased anger, irritability and volatility. Their problems may also have been exacerbated by other factors such as poor sleep. Many of the men with significant substance misuse problems were caught up in precisely this negative cycle, they were spiralling out of control, and the only thing that stopped this from continuing was, tragically, the death or serious injury of a vulnerable infant.

## **A referral does not equal treatment**

30. Another theme that emerged was related to a lack of information sharing and information seeking. Practitioners often erroneously assumed that because a father (or mother) is referred to say, Mental Health or substance misuse services, or a DA programme, or is being overseen by Probation Services, this meant they had actually attended and further, that the programme or intervention had or will lead to a reduction in risk. In many cases the father had not attended or engaged with mental health or substance misuse services and this information had not been passed onto their GPs and if it had, the GP did not pass that information onto any of the agencies supporting mother or baby.
31. All too often attendances following referrals were not verified and assumptions about risk reduction erroneously made. This highlights just how important it is that checks following any form of referral must be made: are they attending and consistently so? Are they engaging or just going through the motions because they are mandated to be there or because Children's Services are on their case? Do they recognise the need to change? Have they shown any signs of attitudinal or behavioural change? Have they accepted, for example, that the relationship was an abusive one and have they accepted responsibility for this? Has their substance misuse actually reduced? Are they taking their medication? Do they meet with their psychologist on a regular basis? What is the feedback about treatment from the psychologist?
32. Related to this is what can only be described as wishful thinking or an overoptimistic appraisal of the efficacy of any treatment or intervention. As noted above in the section on ACEs, where there are extreme experiences of multiple adversity then we have to be realistic about the limits of any of treatment or intervention, and this is especially so for mental health, substance misuse and interpersonal violence. There has to be a realistic acceptance that there are likely to be limits to the extent of internal individual changes that may be possible so that

risk management may largely be through external processes, that is, multi-agency working: ultimately this may involve restricting the amount of contact between high risk fathers and their children.

33. These issues were highlighted in a number of cases:

Father FG was referred to drug services but only attended once and did not engage. This information was not shared with GP and the GP never checked but accepted father's account. It was assumed he was addressing his substance misuse and he claimed he was doing so but this was far from true.

Father ZX had a known history of domestic abuse which was considered to be ongoing with the mother of his children. He also had several previous convictions including for violence. He had been assessed by Probation Services as a medium risk to women and children in 2016. ZX was supposed to attend a 'Building Better Relationships' (BBR) programme through Probation as a condition of his community-based sentence. He was sentenced in this way twice: initially in 2014 and then again in 2017. For various reasons he never actually attended, not a single session.

34. A range of professionals involved assumed he had attended or that he would be breached for failing to meet his community sentence if he did not (in fact, Probation had no intention of breaching him for this or of sending him to prison). Importantly however, despite a multitude of professionals being involved with this family, no one checked whether he had attended the BBR course or not.

35. The BBR course in any case is not directly concerned with reducing violence towards children and is not, as was assumed by practitioners, an anger management programme. The Serious Case Review concluded that: "whenever an agency is providing a specific piece of work with a parent or carer, there is a responsibility to ensure that partners working with the family are aware of the intended outcomes and limitations of that work". There is also a responsibility to find out whether they have actually attended and whether any intervention has demonstrably made a difference.

## **Training / education issues**

36. A number of training or educational issues emerged from the review of these cases.

37. In one case one of the GPs was apparently not aware of the 'toxic trio' as a possible set of risk factors. Whatever opinions there may be about this model and this particular configuration of risk factors, for all the reasons discussed above, professionals need to be made aware of these factors and information about them

must be shared. Whenever any issues arise that involve substance misuse, mental health and domestic abuse, these need to be explored in greater depth.

38. In keeping with the theme highlighted above regarding the potential risks to children of men with anger/mood regulation problems, a low frustration threshold and angry impulsivity, GPs, Health Visitors, Midwives and other professionals need to be made aware of these factors as a 'red flag' or significant warning sign, and especially if any substance misuse is also involved.

39. Finally, in at least two of the cases there was a huge discord between the expectations the men had of becoming a father and the reality. Two of the men were faced with difficulties as fathers that they had never expected and that they were simply not equipped to deal with, they both spoke about having felt isolated and unsupported. In a more general sense therefore, there is a need to educate all prospective fathers about what to expect after a baby is born, about any inevitable stresses that arise and perhaps most importantly, where to seek support should they find themselves struggling to cope.

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