Learning Summary (SILR 13B)

Reason for the Review

This is a summary of a Serious Incident Learning Review (SILR), which was undertaken to look into the circumstances of the four children in the family, who died as a result of a house fire in 2011.

Purpose of the Review

- To consider the circumstances of the children as individuals
- To look at any risk factors
- To identify learning for future practice
- To consider whether the fire could have been predicted or prevented

Family Background

The Mother and the four children lived together in a property and the mother had her own business. The Mother did not appear to receive family support except from her sister. There was little information about Mother's early life.

The Father of the three youngest children had a history of offending, including drug and alcohol related issues and had also been allegedly involved in violence against the Mother (although never convicted).

The Father of the oldest child was known to have a criminal history of drug related and violent offences.

Between 2004 and 2008, there were three incidents of domestic violence – one of the incidents was reported to Social Care; one was reported two months later and the third incident was not reported. A CAF (Common Assessment Framework) was initiated in 2009 and Team Around the Child instigated, whereby one of the children subsequently received occupational therapy support and social activities suggested, with intervention from the Children's Centre (this support continued up until the death of the child).

There was a concern raised by the Police regarding lack of supervision, whereby two of the children were witnessed out in the community frequenting a local shop selling alcohol (this information was not passed on to Social Care).

School made a referral to Social Care (due to one of the children sustaining a number of injuries over three months). An Initial Assessment was completed which concluded concerns about the injuries sustained, through poor supervision.

Review Process

All agencies attended the review meeting and participated fully. Professionals were asked to background information in relation to their involvement with the family.

Agency Involvement

- Derbyshire Constabulary
- Derbyshire Fire Service
- Derbyshire Children and Younger Adults Department
- Derbyshire Community Health Services
- Headteacher (x2 schools)
- Educational Psychologist
- Multi Agency Team (MAT)
- Behavioural Support Service

Circumstances which led to the Review

The fire took place on 25th January 2011 and during the evening prior to this, the Mother and the children were at the home address. During the course of the evening the Mother had been drinking. The children were put to bed at various stages of the evening and the Mother went to bed at approximately 22.00 hours.

At around 23.30 hours, the Mother was woken by her oldest son and by that time the house was full of smoke. As a result of the incident, tragically all of the children died (two were pronounced dead at the scene and two were taken to hospital but later died). Mother escaped through an upstairs window and survived.

The subsequent investigation found the fire to be accidental in nature, noted that there was no fire guard and the smoke detectors had been immobilised or were broken.

Areas of good practice

- The work of schools, Educational Psychology and the Behavioural Support Worker with regard to the input re the oldest child
- The input from the Children's Centre in attempts to engage the Mother and to provide support for the children.

Key Issues Identified within the Review/Missed opportunities

- Several incidents of domestic violence were not referred to Social Care. However, it must be acknowledged that the practice has improved after much hard work. There is still work to do to ensure that school and health staff is aware of domestic violence in households, when there are children present.
- There were two incidents in 2009, when the oldest and second child were found by the Police, unsupervised and wandering a busy area (which should have been referred).
- There was no assessment of the presence of Mother's partner following incidents of domestic violence.
- Mother's third son had a graze to his nose when he was only 5 months old which should have been considered with more scrutiny by the Health Visitor.
- The child care arrangements and issues of safety should have been assessed more carefully in the course of the Initial Assessment.

Summary and Analysis

- The tragic deaths of the children in this family could not have been predicted.
- Despite concerns being expressed about the care of the children over a long period, it was difficult to engage mother to address these concerns.
- She was seen as a hard working person who ran her own business, alongside caring for four young children, with little family or partner support.
- However, she did not always prioritise the children's needs sometimes leading to them being unkempt and hungry (and unsupervised on occasions), leading to injuries in the case of one child.
- She was viewed as defensive to all agencies except the Health Visitor and avoided contact where possible.
- The Mother had been a victim of domestic violence and was involved with partners who used drugs and alcohol related to offending.
- Information from the Police also suggests that she used alcohol, at times to excess.
- It could be argued that the mother had not taken appropriate steps around fire safety, placing the children and herself at risk. However the CPS decided not to initiate criminal proceedings.

Conclusion

The factors that are common in a number of reviews around communication, full assessment of partners and the risks to children of living in households where there is domestic violence are also features in this case. However, these issues in themselves cannot be directly linked to the tragic circumstances in which the children died. It could be argued that mother's failure to ensure fire safety was a contributing factor in their deaths and this matter has been considered carefully by the CPS.

Recommendations

Derbyshire LSCB:-

- Ensure that ongoing work on domestic violence protocol takes account of information sharing with school and nurseries.
- Ensure that the CAF process (now Early Help Assessment/Single Assessment), includes information on fire safety.
- Incorporate Action Plan from Fatal Fire Learning Review into agency procedures.

Derbyshire Constabulary:-

- That all intelligence and other specialist staff, receive further training on recognising factors that could pose a safeguarding risk and to ensure that such information is passed to the Central Referral unit.

Derbyshire Children and Young Adults Department:-

- Managers should quality assure all assessments to ensure that they cover health and safety, domestic violence and presence of fathers/partners.