SERIOUS INCIDENT LEARNING REVIEW - SILR14A

Reason for the Review
This is a summary of a Serious Incident Learning Review (SILR), which was undertaken, to consider the circumstances of two adults and two children who died as a result of a house fire in 2013.

Purpose of the Review
- To identify learning for future practice
- To look at how agencies worked together

Family Background and circumstances which led to the Review
This review concerned two families (who were in the same home at the time of the fire).

The youngest child, alerted by smoke alarms, managed to leave the house but tragically, the child's Mother, the child's Mother's friend and her two children died. The fire was caused by an electrical fault.

The families had contact with agencies and received a number of different services in the year preceding the event. In view of the level of multi-agency involvement, it was agreed to review this case in order to determine whether lessons could be learnt about the ways in which agencies worked together to support these families.

Review Process
All agencies attended the review meeting and participated fully. The professionals involved reviewed all their records and provided timelines of significant events and a brief analysis of their involvement with the families.

Agency Involvement
- Health
- Derbyshire Constabulary
- Education
- Youth Offending Services
- CAYA/Social Care
- East Midlands Ambulance Service
- Substance Misuse Service
- Adult Care

Practice and Organisational Issues Identified

- The importance of reciprocal information sharing between other health services and the substance misuse services.
- The importance of recognising the risk for children involved in drug taking.
- The importance of working together to identify and meet the emerging needs of families.
- The importance of joint working and reciprocal information sharing between agencies in respect of domestic abuse, where children are in the household.
- The importance of “Think Family”.
- The importance of ensuring the safety of vulnerable adults in respect of staff recruitment and staff management in residential care homes.

Areas of good practice

- The programme of education provided by the Fire and Rescue Services to children in schools.
- Social Care completed a thorough Initial Assessment (which resulted in smoke alarms being checked and noting they were correctly placed and functioning).
- Positive feedback received from a surviving family member with reference to the way Social Care worked with them; on the support provided by the youth services (in relation to one of the deceased children) and the good support received from the Emergency Department and nursing staff
- Thorough Assessment undertaken by the prescribing Clinic.

Improving Systems and Practice

- Derbyshire Safeguarding Children Board to ensure that the findings of this report are disseminated to practitioners, in order to maximise the learning from this case.
- Derbyshire Safeguarding Children Board, should raise awareness within schools and educational settings that any child/young person believed to be involved in drug misuse requires a referral to children’s Social Care.
- Derbyshire Safeguarding Children Board should undertake a programme of audit to establish whether the key messages of the strategy “Think Family” have been translated into practice and consider whether a re-launch of the strategy would be helpful.
- Derbyshire Safeguarding Children Board should explore the potential for GP’s to receive information about incidents of domestic abuse.