**Statement under strict embargo until 00:01 Friday 24 January 2014**

Derby Safeguarding Children Board today publishes the serious case review report into case ED12. The death of any child is a profound tragedy and creates distress for the family, the community and the professionals involved. This serious case review concerns the deaths of six children that created national concern and a wish to understand why the events that took place occurred.

The aim of this serious case review was not to investigate the incidents that occurred in May 2012 as this has been concluded by legal process, but to examine closely the work of individual agencies and their inter-agency practice.

The Board concludes that the tragic deaths of the children could not have been predicted or prevented.

However, given the notoriety of the father, the incidents of domestic abuse and visibility of the children, there were some opportunities to get to know the family better although this would not have led to professionals becoming aware that there were plans to deliberately set fire to the house when the children were sleeping.

Christine Cassell, Chair of the Derby Safeguarding Children Board says, “We are all committed to working together to identify children at risk, whatever their family circumstances. Whilst this family lived in unusual circumstances, there is no evidence to suggest that intervention by any agency would have prevented the fire from being set and the tragic deaths of six children.”

Glenys Johnston OBE, the independent overview report author says, “The review has been comprehensive with full co-operation from all agencies involved. Despite the horrific deaths of these children there are few areas for learning for professionals. The sad truth is that no-one could have predicted or prevented the events that took place on 11 May 2012.”

The report makes a number of recommendations for improving practice and procedures and many of these are already in place. For example; systems are in place to ensure information about children in large families is linked together when referrals are received and there are clearer guidelines for police officers when investigating reports of domestic violence to ensure all children's details are recorded and physical checks are made.

Derby Safeguarding Children Board publishes this report to comply with statutory guidance Working Together and the Reporting Restriction Order, upholding the human rights of the surviving siblings to ensure that their welfare is not adversely affected by publication. To achieve this, the report sets out the narrative of the events thematically. This includes a brief overview of the circumstances, prior to a robust analysis of lessons learned in seeking to answer questions about multi-agency practice.

ENDS

Note to Editors:

Further information related to the Working Together statutory guidance can be found at http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

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