*Chair's statement:*

This Serious Case Review is an inquiry into the circumstances surrounding the abuse of a child that could have and should have been prevented at an earlier stage. The LSCB wishes to express its sincere regret at the physical and emotional abuse suffered by this child and his siblings. The LSCB, through the SCR has attempted to cast light on complex and challenging events.

This case relates to the period between mid 2010 and early 2011 and there have been major changes in the way in which services have been configured locally and nationally since this time. Changes in practice across agencies are described in the appendices to the report- alongside a recognition that still more needs to be done. To that end the LSCB attaches its response to the challenges laid down in the overview report.

What is clear is that because of failings in the system this child suffered physical abuse that could have been prevented. The report illustrates all too vividly the need for vigilance in **all services**. It would be an over simplification to describe this case as a series of missed opportunities − they existed but there is more seriously, compelling evidence of individual and systemic failure.

- An overall weakness in follow up collaborative investigation and follow up across all the agencies
- A failure to focus incisively on the children of the family and what life was like for them
- A reluctance to "think the unthinkable" and recognise all the adults in the family as the perpetrators of abuse
- A lack of alertness to the possibility of child abuse as a causation of injury.

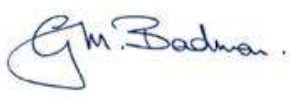
Failures all too common within numerous case reviews.

This is a robust report that does not shy away from the facts. As a consequence of the analysis it presents the partners within the LSCB with a series of important challenges, not least the need to avoid gender based assumptions about abuse and the need as ever to hear the voice of the child – to understand and respond to the child's perspective.

As the appendices make clear, learning has been identified, recommendations have been implemented and actions have been taken to improve communication, realign services and further develop protocols. Arguably it is not more change that is needed but action to ensure that agreed systems are used and their effectiveness monitored and evaluated.

This SCR does not offer excuses and the LSCB is determined to continue to hold agencies to account for the safeguarding of children across Haringey, but neither do the errors in practice in anyway excuse the cruel treatment of an innocent child by those within his family.

Graham Badman



Haringey LSCB Independent Chair