

7 minute briefing: KHALSA – CHILD SAFEGUARDING PRACTICE REVIEW

For all those working with adults, children and families

1. WHAT IS A CHILD SAFEGUARDING PRACTICE REVIEW (CSPR)?

A CSPR (previously known as SCR or serious case review) is a learning exercise that take place when abuse or neglect of a child is known or suspected and a child has died or been seriously harmed.

The review is not about blame. It is about improving practice for the future.



7. WHAT YOU CAN DO

BE CURIOUS

Remember to look/listen/ask/check out/reflect

FIND OUT MORE

- [Bitesize video guide on professional curiosity](#)
- [Professional Curiosity Resource](#)
- [London asthma standards for children and young people](#)

SHARE

Use this 7 minute briefing in team meetings to discuss the findings from this case and how they relate to your service

2. WHAT HAPPENED?

The pseudonym Khalsa was chosen by his father, as a recognition of his child, who he was and his strong commitment to his Sikh faith. Khalsa was being raised by his father following the sudden death of his mother when he was 7 years old which was understandably devastating for the family and they struggled to adapt to the changes. Khalsa was described by those who knew him as kind, helpful and loyal and who sought to do the right thing. Khalsa often presented as “well” which meant that some people involved with him may have underestimated the severity of his illness.

This ‘over optimism of wellness’ created a contradiction for professionals about the possible risks to Khalsa within the safeguarding context. His asthma was said to be “managed”. He also experienced episodes of significant incidents which resulted in emergency medical services being called on 3 occasions prior to his death. On the 3rd occasion, ambulance and hospital staff were unable to revive him and he was pronounced dead on 12 October 2019 with the cause of death given as respiratory arrest due to asthma.

6. RECOMMENDATION: FINDING THREE

The perception of asthma as not being potentially life threatening can impact on how some professionals engage in professional curiosity, specifically in the context of safeguarding.

The WFSCB will incorporate asthma awareness into the Strategic Partnerships planned programme of work for learning and improving practice

5. RECOMMENDATION: FINDING TWO

There is a need to create systems that enable young people to have a voice to influence and participate in their own health plans – specifically when young peoples’ competence to do this is overridden by parental influence.

The WFSCB will adopt and embed the recommended London Asthma Standards for Children detailed in the report from the Healthy London Partnership

3. RECOMMENDATION

Some practitioners do not understand the safeguarding pathways within their own agencies, including but not exclusively, in health. Action required to address.

The Waltham Forest Safeguarding Children Board (WFSCB) will take action to ensure that practitioners are appropriately informed and signposted to safeguarding leads and pathways within each of their own agencies

4. RECOMMENDATION: FINDING ONE

Systems communication between multiple universal and acute medical services and Trusts was not conducive to allowing practitioners to understand and contribute to the risk discussion. At times the right people did not have the right information at the right time.

- The WFSCB will review standard operating protocols to develop more effective systems for sharing information in a timely manner across Waltham Forest and neighbouring boroughs
- The findings from this CSPR will be shared across wider networks to identify further opportunities to improve information sharing processes