Waltham Forest Safeguarding Children Board

Local Safeguarding Partners response to the Child Safeguarding Practice Review for Khalsa

Date 5 January 2021

Introduction

This has been completed under Working Together 2018 and in line with this guidance reflects the principles of a systems-based approach. The review seeks to understand why things happened in the way that they did. What does Khalsa's experience tell us about how systems work? This systems approach focuses on multi-agency professional practice. The goal is to move beyond the individual case specifics and to identify the underlying issues that are influencing practice more generally, the systemic issues, which can lead to changes in practice. The review is not about blame. It is about learning and improving practice for the future. This is reflected in the report format which focuses on the findings rather than sharing the personal details of all the work completed with Khalsa and his family. The detail of which was analysed by the review team and led to the development of the findings.

Who was Khalsa and what happened?

Khalsa had been a resident of Waltham Forest with his father and 3 older, adult siblings. They resided in a 3-bedroom property which the father described as cramped for the size of their family and with issues such as damp which he had been trying to resolve with the local authority housing department.

Khalsa was being raised by his father following the sudden death of his mother when he was 7 years old. The death of his mother was understandably devastating for the family and they struggled to adapt to the changes to their world. Khalsa attended a local secondary school and there were no concerns about his educational attainment or presentation.

Khalsa was raised within the Sikh faith and this was important to him and his family. Khalsa was described by those who knew him as a kind and helpful young person who sought to do the right thing and was loyal to those who knew him.

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.

Khalsa's asthma was said to be "managed" We know from the information presented as part of the review that 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 the 12th October 2019 with the cause of death given as respiratory arrest due to asthma.

Family involvement in the review

Khalsa's father was approached and agreed to contribute to this review. Khalsa's father met with the lead reviewer and a review team member connected to the school. His contributions have been included in this report and we are grateful for this. 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.

Recommendations	
Safeguarding Pathways	**Some practitioners do not understand the safeguarding pathways within their own agencies, including but not exclusively, in health. Action is required to address.**
	Board response **The Board will organise for:** • **Health agencies to provide simple signposting to safeguarding leads in their agencies and to ensure this is regularly discussed in supervision.** • **Clinical Commissioning Group to include in supervision with safeguarding leads discussions on how they can promote their support to others.** • **The role of safeguarding leads/ pathways to be included in to safeguarding training** • **The 7-minute briefing for CSPR Khalsa to highlight the importance of understanding safeguarding pathways in your own agency**
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.**
	Question for the board What changes need to take place between multiple universal and acute hospital trusts to ensure robust and timely information sharing between them?

	Board response **The WFSCB understands that improvements need to be made in how settings make decisions about who will be part of discussions such as complex cases and the use of lead professionals that both gather and share information within their own agency. There is a need to develop more effective ways of these leads sharing information between settings.** **The Board will arrange for:** • **Standard operating procedures to be reviewed by partners with a view to facilitating an effective system for sharing information in a timely manner across Waltham Forest and extending to neighbouring boroughs** • **The findings from this CSPR to be shared with LSPs across London as well as at the North East London Children and Young People Forum with a view to identifying any further opportunities for improving information sharing processes**
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.**
	Question for the board How confident is the partnership that it meets the recommended London Asthma Standards for Children as detailed in the report from the Healthy London Partnership? Board response **The Board acknowledges the report from the Healthy London Partnership and will adopt and embed the recommended London Asthma Standards for Children**

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.**
	Question for the board How will the partnership increase awareness of asthma and its management across agencies and communities in Waltham Forest? Board response **The WFSCB will incorporate asthma awareness into the Strategic Partnerships planned programme of work for learning and improving practice which will include the following:** • **Marking World Asthma Day** • **Dissemination of the 7-minute briefing** • **Incorporating an asthma case study into safeguarding training across the partnership** • **Including a case relating to asthma into future briefings about challenging conversations**