

October 2025 – FIVE MINUTE BRIEFING: For all those working with adults, children and families

LCSPR Children M

A local child safeguarding practice review (**LCSPR**, previously known as SCR or serious case review) is a learning exercise that takes 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.



1 About the family

Children M were a white British, large sibling group, living with their parents.

The children who were home educated ranged from nursery to college ages, with varying additional needs including non-verbal communication and limited social skills. The household conditions presented significant concerns after one of the children was found alone in the street wearing only a nappy and brought back home.

2 Aim of this LCSPR

The LCSPR looks at a six-year period during which the children experienced cumulative neglect; unsafe home conditions, missed health appointments, delayed development, poor social opportunities, and older siblings caring for younger ones.

Children M's circumstances echoes the neglect findings from another recent LCSPR for Children L. Building on that learning, this review underscores the challenges within the national system of elective home education (EHE), and the complexities agencies face in balancing children's rights, parental responsibilities, and information sharing.

The Review set out to understand how agencies assessed and safeguarded Children M, especially given their invisibility to services due to EHE, by looking at information sharing, agency oversight, and the impact of parental decisions on children's wellbeing.

3 What this LCSPR found

Five key findings:

Unseen Children: Agencies knew about EHE but did not see children at home for years. The EHE system relied on parental reporting, with limited direct contact.

Children Not Brought to Appointments: Persistent missed health appointments were not effectively escalated. Health services did not always follow 'Was Not Brought' policies, limiting opportunities to assess the children's wellbeing.

Information Sharing: Siloed practice and unclear protocols led to gaps in significant information being shared between agencies, impacting coordinated safeguarding responses.

Think Family: The family's dynamics, including parental dissatisfaction with SEND support and reliance on self-reporting, were not sufficiently explored. The dominant parental voice overshadowed individual children's needs.

Learning from Reviews: Limited multi-agency opportunities to learn from statutory reviews have meant recurring themes (e.g. neglect, escalation, invisible children).

4 What's being done about this review?

The Safeguarding Partnership is now in the process of implementing five recommendations which includes new working groups, reviewing services and refreshing how we work as a partnership.

The findings and recommendations from LCSPR Children L are closely connected to this review so we will ensure that improvement work is appropriately aligned.



5 WHAT YOU CAN DO NOW

- **SHARE this briefing widely** along with
 - LCSPR Children M and [LCSPR Children L](#)
- **STRENGTHEN your understanding of Elective Home Education**
 - Familiarize yourself with [Waltham Forest EHE Protocol](#)
 - Watch the [National Panel's Webinar on EHE](#)
- **BE PROFESSIONALLY CURIOUS:**
 - If you work with EHE families, seek opportunities to understand the reasons for home education and each child's needs
 - Consider why children aren't being brought to appointments
 - [Use this resource](#) to reinforce your professional curiosity
 - Think Family - Consider the needs and roles of all family members, not just the dominant voice.

Visit
www.walthamforest.gov.uk/strategicpartnerships
for more resources