

Local Child Safeguarding Practice Review

“Out of Sight” **Safeguarding Children in Elective Home Education:**

Children M

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1. Introduction

1.1. A statutory local child safeguarding practice review (LCSPR) was commissioned in March 2024 by the Waltham Forest Safeguarding Children Board (WFSCB) via the One Panel¹, to analyse how agencies understood the quality of care provided to six children. The sibling group are referred to as Children M and are white British. Children M lived with their parents, Mr & Mrs M in Waltham Forest. All the children were electively home educated (EHE²), three of which were assessed as having autism spectrum disorder (ASD)³, with one child having an Education, Health Care Plan⁴ in place.

1.2. Recent figures show that in the Autumn of 2024 as many as 111,000 children in the UK were taught from home and this number is increasing⁵. There are many reasons why a parent may decide to home educate. Choosing to home school children is of course a parental right. Current data⁶ shows electively home educated children are no more likely to experience harm from their parents than the general population. As shared by the Children's Commissioner⁷ home education is not, in and of itself, a safeguarding risk. A parent's right to educate their child at home applies equally where a child has an Education, Health Care Plan (EHCP). Local authorities have a duty to review EHCP's annually, following procedures set out in the Special Educational Needs and Disabilities (SEND) Code of Practice: 0-25 years⁸. Annual Review Meetings are convened and chaired by the Special Educational Needs (SEN) casework Officer.

1.3. Waltham Forest Elective Home Education falls within the remit of the Behaviour, Attendance and Children Missing Education Service (BACME⁹). In line with DfE Legislation the local authority only registers children for EHE if they are a resident of Waltham Forest and of statutory school age (5 years to 16 years). Local data (as reported in late 2024) shows there are 377 children who are electively home educated in the borough. The data details the gender; age; ethnicity and reason for the child being home educated alongside whether the child is subject to children's services statutory interventions and/or special educational need, including an EHCP. The Waltham Forest Elective Home Education Protocol¹⁰, updated in December 2024, provides guidance to families, schools and all other agencies on the protocol and procedures when a parent decides to home educate a child of compulsory school age.

1.4. The Review considers the very real practice and system challenges faced when children are out of sight of agencies and how links are then made between EHE and understanding likely and/or actual significant harms¹¹. Children M's situation highlights the current national system of elective home education and the local system complexities that agencies encounter when balancing the rights of children, the rights, and responsibilities of parents, sharing information across agencies, and ensuring children's worlds are understood for those children who need protecting from risk of harms. Children

¹ One Panel is the local mechanism for how decisions for statutory learning reviews are determined.

² Elective Home Education is the term used by the Department for Education to describe the education provided by parents at home, rather than providing education for their children by sending them to school. This is different to home tuition provided by a local authority or education provided by a local authority other than at a school

³ ASD is a developmental disability that affects how individuals interact with the world, communicate, and learn. It is characterised by difficulties with social interaction and communication, as well as repetitive behaviours and interests. ASD is a spectrum disorder, meaning the symptoms and their severity can vary greatly from child to child

⁴ An EHCP is a legal document that outlines the specific special educational, health and social care needs of a child or young person aged up to 25 years old

⁵ <https://explore-education-statistics.service.gov.uk/find-statistics/elective-home-education>

⁶ <https://explore-education-statistics.service.gov.uk/find-statistics/elective-home-education>

⁷ Children's Commissioner report: [Lost in transition? The destinations of children who leave the state education system](#)

⁸ [SEND Code of Practice](#) - Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities

⁹ BACME is part of the council's wider services led by the Director of Education that includes SEND, School Improvement, School admissions, Post 16, School commissioning and Business Support.

¹⁰ [Waltham Forest Elective Home Education Protocol](#)

¹¹ Significant harm refers to a threshold of statutory intervention and is defined as ill-treatment or impairment of a child's health or development. The harm is serious and significant to impact a child's well-being compared to children of a similar age/development

M's story shows how, in some situations, elective home education can lead to the isolation and invisibility of children, when coupled with a parental avoidance of services, (which are in place to check a child's health, development and well-being), and this can result in serious and significant harms for children being endured. The findings of this LCSPR will be seen in many other local authorities across England who are grappling with the issues identified locally.

1.5. This Review appreciates the considerable time and efforts by all agencies involved in preparing written evidence and who attended the Learning Event. Thanks go to all who contributed.

2. Summary of Children M's Story

2.1. The sibling group comprised of children and young people who were of a statutory and non-statutory school age. This included children who were of an age to have attended college, secondary school, primary school, and nursery provisions. The following is a summary of their individual characteristics known to the multi-agency professional network:

Child & Young Person / Age	Gender	Additional Need
Child 1 :19 years	Male	ASD / EHCP/ non-verbal
Child 2: 15 years	Female	Verbal / non identified
Child 3: 10 years	Male	ASD / limited communication
Child 4: 8 years	Male	Autism/ limited communication
Child 5: 4 years	Male	None identified/ limited communication
Child 6: 4 years	Male	None identified / limited communication

2.2 The court bundle reviewed for this LCSPR show Children M experienced cumulative harms which impacted significantly on their safety, and on all areas of health and development. The childhood neglect¹² included:

- Unsafe and unclean home conditions
- Lack of adequate parental supervision with physical risk to the children's safety
- Limited toilet training which resulted in incontinence
- Children not meeting expected milestones or exceeding milestones, with obesity seen
- Failure to take to health appointments for follow-up appointments
- Significant delay in communications skills, with some children being non-verbal
- Poor social skills and no opportunities for peer friendships or group activities
- Inadequate home education impacting on social and educational progress
- Older children providing caring responsibilities to younger children
- Low self-esteem in older children and self-harm behaviours as emotional needs were not met
- A range of extreme behaviours, which suggested all was not well in their worlds

¹² The Children Act 1989 defines neglect as the persistent failure to meet a child's basic physical or psychological needs, resulting in significant harm to their health or development.

2.3. This LCSPR covers a 6-year period from 2018 to 2024. Despite the length of time under review, the records available regarding the individual children are limited due to a variety of factors. These include changes in the way information was recorded and held, services not knowing about the children and therefore not being involved, limited input from services and therefore limited records, with Children M not being brought to appointments and the legislative framework around EHE where children are not required to be seen. A summary of the collated multi-agency story regarding what is known and what actions/services were offered is provided below.

<p>Contextual History 2015</p>	<p>Mr & Mrs M are increasingly dissatisfied with the special educational needs support and provision with the eldest child</p> <p>Child 2 reports they were inappropriately touched by another child at primary school</p> <p>Outcome: Parents decide to EHE all school age children as they feel nothing has been done and their children are not safe in school</p>
<p>2018</p>	<p>Speech & Language Service (SALT) refer to Waltham-Forest MASH¹³ due to several health appointments where Children 1, 3 & 4 were not brought (including Speech & Language/Audiology/Child Development Team). Ranging from Child 1 not being brought to 80% of SALT to approximately 40% of appointments for Children 3 & 4</p> <p>Outcome: Child & Family assessment completed by Waltham Forest Children's Services with no further action as it concluded Children M's needs were being met by their parents. The recorded quality of the home visits and lack of analysis in the statutory assessment have been identified as not typical practice then or now in Waltham Forest Children's Services</p>
<p>March 2019</p>	<p>Children 5 & 6 – twins born</p>
<p>April 2019</p>	<p>Health visitor's new birth face to face visit to twins – low birth rate: no concerns identified regarding quality of care</p> <p>3 x visits in May 2019 – no concerns identified regarding health and development. (Children 5 & 6 drop down from Universal Plus to Universal Health Visiting Service¹⁴)</p>
<p>April 2020</p>	<p>COVID-19 Pandemic. Remained at Universal Care Pathway</p> <p>Virtual 1 year Health Visiting developmental check</p> <p>Limited responses seen from Mrs M – self-reports children are “fine”</p>
<p>January 2021</p>	<p>Continued pattern of Children not brought to health appointments</p> <p>SALT call a Team Around the Family Meeting (Virtual) due to pattern of missed health appointments. Outcome: further SALT assessment; held virtually due to COVID-19</p>
<p>July 2022</p>	<p>Service Change: Transfer of health records from Northeast London Foundation Trust (NELFT) to Tower Hamlets GP Care Group (THGPCG)</p>

¹³ A Multi Agency Safeguarding Hub is a unit that brings together various agencies including children's services, the police, health, and education to share information and coordinate work to safeguard children by ensuring effective and timely interventions where required

¹⁴ In health visiting, “universal plus” refers to targeted support when specific needs arise, this could include parenting support or advice on feeding/sleeping. “Universal” refers to a service provided to all families with young children; there are 5 mandated contacts including a pre-natal visit, a new birth visit, a 6–8-week review, a one-year review and a 2-year review.

	Twins' health and development not flagged as remained on universal care pathway
July & September, December 2023	2 Police reports following neighbourhood disputes: No action required; advice given 3 Housing Agency reports; neighbour disputes logged and safeguarding concerns regarding children. Outcome: Anti-social behaviour case opened
February 2024	Safeguarding concern reported to Housing by worker who has been in the home to undertake repairs. Not escalated to statutory services.
February 2024	Police report: Child in street wearing only a nappy, child returned home. Police refer to MASH. Outcome: No further action seen due to MASH & Police reported system errors
March 2024	Child alone in street wearing only a nappy. Home conditions of concern. Police delay in action taken (1 day). Outcome: Children M are removed under police protection ¹⁵ , with urgent referrals made to Waltham Forest Multi-Agency Safeguarding Hub ¹⁶ and Children M are temporarily placed with a family member.

2.4. Criminal investigations and care proceedings commenced in March 2024, and Children M now live in various family and local authority provided homes, under child in care arrangements. They spend time together as a family to ensure relationships are promoted and maintained.

2.5. Single agency internal investigations, learning and actions have been taken by the Housing Agency and the Metropolitan Police regarding failures and delays in reporting and taking timely safeguarding action.

3. Scope & Key Questions for the LCSPR

3.1. This LCSPR is written to provide system and practice learning, having analysed information collated by agencies involved with the family and following a Reflective Learning Event at the end of 2024. The specifics of the children's story and single agency learning are held by the WFSCB and the relevant partner agencies. The Review is aligned with themes seen in other LCSPR's¹⁷ and the National Panel Briefing¹⁸, where elective home education is highlighted as a key contributory factor.

3.2. The Review paid attention to the legislative context and role of statutory agencies when children are home educated and the complexity that this can bring to practice. As outlined in Section 7 of the Education Act 1996 it is the responsibility of the parent to ensure their child, of compulsory school age, receives a suitable education. This means there are no specific legal requirements, and the education at home does not need to include any particular subjects or pay attention to the National Curriculum or for examinations to be taken. There is no requirement for parents to follow a typical "school day" or to take school holidays – this provides the parent with autonomy and flexibility in how to teach their child.

¹⁵ Under Section 46 of the Children Act 1989, where a police officer has reasonable cause to believe a child would otherwise be likely to suffer significant harm, the child may be kept in or removed to suitable accommodation where they may be protected

¹⁷ [Gloucestershire & Surrey LCSPR](#), [Derby & Derbyshire LCSPR](#)

¹⁸ [Panel Briefing 3: Safeguarding children in Elective Home Education](#)

As set out in the Children Act 1989 and the associated statutory guidance¹⁹, agencies do have a duty to safeguard children where there is evidence that they may be at risk of significant harm²⁰. Information for local authorities on EHE is set out in the Department for Education's non-statutory guidance²¹.

3.3. With this legislative context in mind, the Review set out to understand how agencies understood the lived experiences and safeguarded Children M when they were electively home educated, paying attention to their individual range of needs.

3.4. Consideration has also been paid to the Waltham Forest Safeguarding Partnership Arrangements²² to ensure learning and improving practice are at the centre of the work of the WFSCB. Similar themes are identified in this Review compared with previous LCSPRs²³ and a very recent Rapid Review of a perplexing situation and chronic neglect of a 10-year-old child known to statutory services as Child J. The identified learning from the recent Rapid Review has been analysed and included within this LCSPR. It shows a “near miss” situation and mirrors the learning in a previous review in Waltham Forest ([Children L](#)). Likewise, Children M raises questions about how the safeguarding networks identify and intervene in situations of childhood neglect and when situations present as “perplexing”. Similar themes are seen regarding how effectively a “think family” approach is embedded when working with parents so as to understand motivations and capacity for change to ensure children’s day to day needs are persistently met. System learning is identified regarding the consistency of multi-agency information sharing; multi-agency challenge and escalation when situations do not improve for children and ensuring the voice and experiences of children are known as part of understanding the impact on them.

3.5. This review has explored the learning opportunities available to partner agencies, including multi-agency training, events, and resources, to foster a culture of learning and ensure knowledge from reviews is applied in day-to-day practice. The voices of a cohort of multi-agency frontline practitioners/managers are shared, along with recommendations for strengthening multi-agency workforce development spaces at the end of section 4.

3.6. There have been various attempts to offer the family, including the older children, the opportunity to participate in the review process. To date the family have not felt able to do so. This report therefore relies on analysis of professional perspective and does not include a family view. Where possible and known, the views of the Children are incorporated in the learning.

4. Findings and Learning Points

4.1. Overall, this Review concurs with the conclusion of the care proceedings which evidenced Children M had experienced chronic neglect whilst in the care of their parents and this significantly impacted on their development. Due to a variety of factors, including Mr & Mrs M’s own needs and the large sibling group of children to care for, it was likely too much for Mr & Mrs M to persistently meet their children’s

¹⁹ Statutory guidance: [Working Together to safeguard children 2023](#)

²⁰ Departmental guidance for local authorities on Elective Home Education states that “A failure to provide suitable education is capable of satisfying the threshold requirement contained in s.31 of the Children Act 1989 that the child is suffering or is likely to suffer significant harm. ‘Harm’ can include the impairment of health or development, which means physical, intellectual, emotional, social or behavioural development, so the provision of unsuitable education clearly can amount to this. The causing of significant harm need not be intentional or deliberate, but case law¹² indicates that it must be ‘considerable, noteworthy or important’. This is a key point for local authorities in considering whether the use of safeguarding powers is appropriate in a case relating to the home education of a specific child. However, local authority staff should be clear that when the use of safeguarding powers is justified, they should be used.”

²¹ [Departmental guidance for local authorities: Elective Home Education](#)

²² [Waltham Forest Safeguarding Partnership Arrangements](#)

²³ [Waltham Forest statutory reviews and One Panel](#)

range of needs, especially as the children were all home based. As one child said “*I guess the house wasn’t all that, it was a lot to do, looking after the little ones and some had extreme needs. It was stressful; they (Mr & Mrs M) tried their best*”.

4.2. In summary this LCSPR finds the safeguarding system as a whole in Waltham Forest did not understand Children M’s experience of elective home education as they remained largely out of sight to agencies for a six year period. The national legal EHE framework at the time limited the powers of the local authority, and locally a more coordinated and inquiring approach was required to understand the parental capacity and motivations to ensure they persistently met Children M’s range of needs whilst at home in their care.

4.3. The five findings and learning areas set out in this section are linked to 5 specific recommendations in Section 7. The findings are aimed at improving the system responsible for the safety and wellbeing of children and young people and to try to reduce the chances of this happening again to children in Waltham Forest. The WFSCB takes overall responsibility to lead, coordinate and implement the local learning recommendations so that it is translated into action plans, which show a measurable impact for children and families in the borough.

4.4. The review also provides system and practice reminders which are not recommendations, but which serve as an aide memoir when working with children and their families who are electively home educated. The aim being to try to address some of the risk of harm factors and to help protect this group of children from abuse, which is set within the changing national landscape for children who are home schooled.

4.5 Elective Home Education: Unseen Children

4.5.1. Finding 1: Key agencies knew Children M were being home educated and statutory oversight was as per expected local and national guidelines. The impact of the elective home education was not understood by statutory agencies as the children were not seen in their home for a significant period of time.

4.5.2. As per the national framework for EHE, Waltham Forest local authority had no formal powers or duty to monitor the provision of Children M’s education at home and there was no requirement for the children to be seen. Under Section 436A of the Education Act 1986 they did identify Children M as being in their area and not on a school roll. A recent Ofsted²⁴ inspection of WF Children Services provisions regarding children who are not in school shows “*there are robust systems in place to identify Children not in school, which link together with elective home education*”. This Review concurs with this in terms of Children M’s home education being known to the BACME Service.

4.5.3. Waltham Forest had a system in place that worked for recording and tracking the progress of individual children educated at home. The approach complied with national legislation and guidance with the BACME Service reviewing the Education Plans of children annually. The review process takes place through informal enquiries and parents have the option of providing the education plans by post or email. Some parents will submit photos or other forms of evidence to support the review process. Where a home visit is requested, the service arrange a suitable time and date. The vast majority of EHE parents in Waltham Forest choose to have their review happen remotely.

²⁴ [Ofsted report on the Inspection of Waltham Forest’s children services](#)

4.5.4. The EHE was seen as suitable by the BACME Service during the period under review and no concerns were highlighted at any early help or statutory level of need. The family submitted yearly education plans to BACME, which had management oversight from three frontline managers, all of whom agreed that the plans submitted met nationally mandated and Waltham Forest's own definition of a suitable full-time education for each child. The plans differentiated between each child's individual needs and demonstrated from the parent a range of resources being used including lists of books and different learning platforms used. The range of subjects and areas of interest being explored, and the diversity of learning was described as encouraging to see. The language used within the education plans was positive, child centred and imbued with a warmth and understanding of the children's needs and interests. The information did not indicate any cause for concern that Children M were not receiving a suitable education.

4.5.5. As DfE guidance states: *"there are no detailed legal requirements as to how such a system of oversight should work, and it is for each local authority to decide what it sees as necessary and proportionate to assure itself that every child is receiving a suitable education, or action is being taken to secure that outcome"*. The BACME Service view is that a relationship had been established between the local authority and Mrs M, in particular. And in comparison to education plans received from other families, the level of detailed provided by Family M was above the normal level seen. It included direct work with the children who were verbal on their feelings around being home schooled and adequately captured their voices in this respect. There is limited information regarding seeing and hearing the lived experiences of the non-verbal children.

4.5.6. A home educated child is less visible than a child who regularly attends school. This inevitably made it more difficult to have opportunities to have "sight" of Children M and afford them the protective factor that being in a primary and secondary school could offer. Simply put, professionals were not aware and therefore did not have evidence that all was not well for Children M. This meant the typical responses and steps taken to protect them and ensure their safety and welfare were limited by statutory agencies. Statutory agencies did not know Children M were at risk of harm due to the quality of the home conditions and parenting available to them until the February 2024 incident, as no one was entering the family home on a regular basis or building and sustaining face to face relationships with any child or parent.

4.5.7. There is no legal obligation for a parent to agree to a home visit for the purposes of monitoring the education being delivered. An Elective Home Education Service does not have any statutory powers in this respect to enforce a home visit to a parent unless safeguarding concerns are apparent. The constraints and barriers to seeing any child who is EHE were consistently shared across all partner agencies involved at the Learning Event. The practice complexity in this situation was that as with other children educated at home, the BACME Team did not have a right of entry to the family home to check that the provision being made by the parents for the child with special educational needs was appropriate, and they could only ever enter the home at the invitation of the parents.

4.5.8. The impact for Children M resulted in them not being seen by any professional in their home for an extensive period of time (6 years). Children M were not visited nor seen by the BACME Team as the notes show *"family last seen in person in 2018"*. Rather, the BACME Service rely on building a positive working relationship with parent(s) to establish trust, whereby a home visit would be accepted as a form of support if the parent agreed to it. In this situation there is evidence in the body of emails provided that shows a working relationship was built between the frontline BACME EHE officer

supporting Family M, with examples of advice given and with referrals on to services and support as requested.

4.5.9. The Children's Wellbeing and Schools Bill, introduced in December 2024, proposes changes to elective home education, including new safety measures and interventions for local authorities. This includes a compulsory Children Not in School register in every local authority in England. There will no longer be an automatic right to home educate their child if the child is subject to a child protection investigation or plan. And, if the local authority deems the education and /or home environment unsuitable they will have a power to intervene and require school attendance. As stated, "*the measures will ensure that the most vulnerable children cannot be withdrawn from school until it is confirmed that this would be in their best interests, and that the education to be provided outside of school is suitable*"²⁵

4.5.10. In this situation however this may not have made a positive difference to Children M as they were known to be home schooled and yearly reviews held. Children M were arguably not being deliberately hidden from view, although equally the current agency systems in place did not fully identify what was happening and put plans in place to address the children's range of needs from a health, education, care, and safety perspective. Children M remained unseen by the professional network when at home in their parents' care. With this in mind, the Review considers what other opportunities there were to see Children M and build a multi-agency picture of what life was like for them. The Review is mindful of the Strengthening Home Education Committee's²⁶ recommendation made to Government which was not accepted regarding the DfE providing local authorities with a set of clear criteria against which the suitability of education can be assessed, considering the full range of pedagogical approaches taken in EHE, as well as the age, ability, and aptitude of individual children, including where they may have SEND. This recommendation and suggested guidance may well have been helpful in Children M's situation.

4.6 Elective Home Education & Children who are Not Brought to Health Appointments

4.6.1. Finding 2: A more persistent stance was required by all health services when Children M were not seen when not brought to appointments. Hospital and Community Health services needed to adhere to their 'Was Not Brought' policies to ensure Children M were seen.

The lack of effective escalation by agencies meant Children M's worlds were not understood and the situation did not change.

4.6.2. The predominant regular opportunities to see Children M were by community and hospital health services given that there were no requirements under the local authority EHE framework to visit and see the children. Hospital records show, apart from a Paediatric Audiology Follow-Up Appointment for one child, and a SALT assessment for Children 3 & 4 in mid 2022, the sibling group of children were not seen by any hospital professional after May 2019. The opportunities to see the children face to face in the community via GP consultations were also limited and tend to show phone consultations, often with Mrs M. Records show that the NELFT community health professionals who had access into the family home in 2018 and lastly in early 2019 showed no evidence of persistent failure to meet the children's range of needs; for example, the home was described as clean and tidy and the children all

²⁵ The Education Hub: The Children's Wellbeing and Schools Bill: what parents need to know Gov.uk, December 2024

²⁶ Strengthening Home Education Committee's²⁶ (July 2021)

clean and in appropriate clothing for the time of year. Thresholds remained at Universal Level of Need Pathway.

4.6.3. Health information submitted as part of this Review show there was a pattern of missed appointments seen from 2018 onwards, including children not brought to GP appointments for immunisations and hearing checks, along with not being taken to speech & language appointments. This in itself does not constitute significant harm but does require a more professionally curious stance to ensure the barriers to parents ensuring children are taken to appointments are known, addressed and children seen. There are of course many reasons why appointments are missed. Having procedures in place to minimise the possibility of this and/or to respond effectively when it happens, ensures an effective use of clinical time, a reduction of risks associated with treatment non-adherence and ensures children's health needs are met. Understanding why a child is not being brought by a parent for a health appointment is important as it may be an indicator that the care of a child is potentially being neglected, and consideration given if patterns are seen as to whether further safeguarding enquiries are required. Not being brought to appointments is seen as a recurring feature in many learning reviews²⁷, both locally and nationally.

4.6.4. Health professionals particularly those working in the community can frequently come across families where gaining access to the home has been difficult or impossible as well as where there is a pattern of non-attendance and cancellation of important health appointments as in this situation. Health professionals explained there were various reasons given for not bringing Children M and all appeared plausible at the time and shared by Mrs M in the main in a respectful and articulate manner. The need for conversations which provide an opportunity for high support, along with high challenge are helpful in such situations where barriers are unpicked to ensure children attend health appointments and their development is not impacted.

4.6.5. Some persistence was seen in that the family were kept open to SALT, with a Team Around the Family (TAF) Meeting held in 2021 when repeat patterns of missed appointments are shared with other professionals. As explained at the Learning Event these missed appointments were joined together at this meeting but not effectively escalated further with impact for the children. In understanding why this might have been, professionals shared how their efforts to address the parental non-compliance "fizzled out", likely due to working under the restrictions of COVID-19 and the resultant impact on health services' capacity. The Community Paediatric Team also shared how barriers to escalation often include not knowing who to escalate to and whether this is the right professional at the right level. It takes time to find this out and then there are reported delays in hearing back on what action has been taken. Hospital health professionals also commented on service capacity issues when children are not brought to appointments and how at the time the practice tendency was to discharge the child from the service. This was not seen with the SALT, with tenacity evidenced in keeping the children open to their service.

4.6.6. In such circumstances, good practice recommends that health professionals undertake a holistic risk assessment of the child(ren) or adults, including reviewing the health records (electronic and paper) and liaise with other professionals and agencies to find out whether there is any other information that would suggest increased vulnerability or safeguarding concerns. The professionals should then document their plan of action with a clear rationale. This approach is documented in the revised THGPCG Policy "*Was not Brought*" available to all School Nurses and Health Visitors in the Borough. The process being, for the management of missed appointments, that as soon as reasonably

²⁷ [Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014](#)

practicable following a missed appointment the professional must review the current risk assessment and existing care plan. There should be contact with the family and consideration of what next steps should be taken once the reason for the missed appointment is considered and include a future appointment, followed up by a letter to confirm details. For General Practice the 'Was Not Brought' policy is captured in the Northeast London primary care safeguarding handbook²⁸. The GP notes seen for this Review record Children M were not brought to appointments but with limited evidence seen that the handbook was followed as required by GPs. Action already underway as a result of this Review includes THGPCG 0-19 services reviewing and strengthening existing multi-disciplinary team guidance and practice reminders during Level 3 training.

4.6.7. There were several missed opportunities for professionals to effectively escalate matters when progress was not seen, as cited above with the 2021 TAF meeting called due to concerns regarding the Children repeatedly not being brought to clinic. The initial action plan agreed at this meeting was appropriate but not followed up when engagement remained poor. A further example is seen when Mr & Mrs M raised their other two children's additional learning needs with the BACME Team. Efforts are seen in this team requesting SEND involvement, but they did not receive a response, and this was not followed up or escalated. What was needed was a more coordinated approach to discuss and plan so as to align EHE with other support services. The EHE service did highlight this as a concern for the children in this family and more widely for all children in 2020 and 2021, but this was not formally escalated and so with limited impact for Children M. The lack of effective escalation for children is a recurring practice theme in the Waltham Forest Safeguarding Partnership. It is proposed that escalation is included as one of the WFSCB's priorities in their strategic plan 25-28 as per recommendation 4.

4.7 Elective Home Education & Information Sharing

4.7.1. Finding 3: The current EHE System highlighted challenges regarding what information could and could not be shared about the family. This resulted in a siloed practice approach across the Partnership with gaps in significant information being known to key agencies to ensure effective working together.

4.7.2. The practice dilemmas regarding consent to sharing information when children are EHE were seen as significant in this Review. As perennially highlighted in local and national learning reviews²⁹, effective and timely sharing of information between practitioners and agencies is essential for early identification of need, assessment, and service provision to keep children safe. The review heard how frontline professionals felt there were limitations to sharing information as no safeguarding concerns were identified and this resulted in a full picture not being seen as some agencies did not know key pieces of information. This issue is seen across local authorities in England and has also been highlighted and debated by the National Panel in a recent EHE Multi-Agency Webinar³⁰.

4.7.3. Professionals shared at the Learning Event the information sharing challenges faced in Children M's situation, where there were no specific risks or harms identified via the BACME Team through the annual EHE procedural arrangements. Such EHE legislative requirements do not stipulate a monitoring function of the local authority, as the law is to identify those children only who are home educated and as afore explained, there were no obvious reasons regarding a statutory need to see the

²⁸ ²⁸ [Primary Care Safeguarding handbook \(June 2024\) – North East London](#)

²⁹ [Research in practice – Triennial Analysis of Serious Case Reviews \(2011 – 2014\): practice briefing for health professionals](#)

³⁰ [Child Safeguarding Practice Review Panel: EHE Webinar](#)

children at home as the significant harm threshold had not been seen to be met. This LCSPR highlights that the WF EHE Policy Guidance³¹ would benefit from including specific information sharing protocols between the BACME Service and health agencies which is fully compliant with general data protection regulation (GDPR). This is further considered in Recommendation 1.

4.7.4. Through analysis and discussions at the Learning Event, the below summary of the gaps in effective information sharing are provided to show a cumulative impact of the lack of coordinated responses for Children M.

a) The autism diagnostic reports from Waltham Forest Community Paediatrics and the Educational Psychology Team did not reach the BACME Team to inform of the additional needs of Children 3 & 4. Both children were below compulsory school age, and therefore BACME would not have been involved with them at this time. At this time, it has been shared that there was less consistency in copying reports to other agencies. There has been internal learning regarding information sharing, it remains an area of challenge when the threshold for concern has not been met.

b) This had a resultant impact on the SEND and BACME Team responding to these two children's additional needs when reaching school age, and then appropriately aligning services and managing and supporting the family more effectively. It was known that Mr & Mrs M had a growing dissatisfaction with the local SEN support and provision to the oldest child who had a diagnosis of autism, and this formed part of their decision to home educate. Educating at home a child or a number of children who have special needs is often more difficult and local authorities should do their best to ensure that children with additional needs receive a suitable education at home and this continues to be the case over time. Close and effective working together therefore between BACME and the SEND Team is critical to ensure there is a robust assessment and review system in place to ensure what is being provided remains suitable to the child's needs. More effective join up was required. Community Paediatrics reflect upon how they also had no clear pathway from the BACME team at that point and no guidance from SEN regarding Mr & Mrs M choosing to home school children with additional needs. Questions were raised repeatedly in multiagency forums as to what the pathway was and what the expectation was from the BACME team and SEN in that circumstance, however no answers appear to have been received nor escalation seen to clarify matters.

c) Despite three of the children having diagnosed additional needs, only one child in the sibling group had an EHCP and support from the SEND Team. There were delays seen to the EHCP annual review. The Review has not been able to unpick the rationale for this drift.

d) Housing had key information regarding Family M which included the home conditions and Children M's presentations, including safeguarding concerns. These were not shared as per statutory guidance. There has been single agency learning from the housing department regarding the need to share information with the safeguarding network, with training issues highlighted and work underway to address this.

f) There were issues in the handover and transfer of information when there was a change in health service provider. Tower Hamlets GP Care Group (THGPCG) provided the 0-19 Service in Waltham Forest from July 2022 following the transfer of the service from NELFT. Historic

³¹ [Waltham Forest EHE Protocol](#)

concerns had been raised by NELFT practitioners for the Children not being brought to appointments and their identified health needs. At the time of transfer to THGPCG the children's care was being managed by the targeted children's service and were under Universal caseloads and not open to children's social care. At the time of transfer to THGPCG as directed by THGPCG, only children under five and open to children's social care records were transferred. Under universal services it would therefore not have necessitated a home visit or face to face contacts with the EOTAS School Nursing Team³². This is a repeat system theme identified in previous learning reviews.

It is recognised that when children move from one commissioned service to another there are risks that they may be lost to follow up. Commissioning services need to ensure statutory safeguarding partners are consulted and included in drafting any tenders and decisions when awarding new contracts. Health providers involved in this review have shared how there is a need to strengthen planning and preparation for change of provider which includes a detailed transition plan which has realistic timescales and involves children and families affected. Monitoring and evaluation of the transfer is required, and adjustments made as needed to ensure children's wellbeing and safety.

g) There were identified recording system issues which became apparent as part of this LCSPR in the MASH. This resulted in significant Police information in February 2024 not being responded to as a significant safeguarding incident a month prior to the March 2024 serious incident being known. Senior Managers in CSC have reviewed this serious information sharing error and determined it is likely due to one off human error in the information being uploaded on the necessary electronic systems.

As a result of this identified issue by the Independent Reviewer, significant searches of electronic systems were undertaken with the assistance of Business Support and I.T. colleagues. No trace was found of the Police report being received into the local authority mailbox. On further checking with Police colleagues, they provided a record of the report having been sent. Unfortunately, it has been impossible to definitively identify if the report was received, or whether through technical or human error that this was filed incorrectly. The MASH has reviewed the systems and processes with appropriate colleagues and found that this was an anomaly and not usual practice. They continue to monitor and check referrals received with Police colleagues and review processes within the MASH, so a similar error does not occur again.

4.7.5. The Review has debated what can be done in such situations regarding sharing information between agencies when a child is EHE and there are limited professional concerns. The discussions have centred upon a focus on the work with families from the outset of their decision to electively home educate. In this situation, with the benefit of hindsight, this would have meant unpicking the parental dissatisfaction around the eldest child's SEN support and provision and helping the female child and family recover and rebuild from the incident that happened at primary which likely resulted in the family losing faith in their children being kept safe whilst in school. This means seeking to establish a multi-agency working environment together with families, which has at its heart information sharing. This

³² The Education Other Than At School (EOTAS) Nursing Team are responsible for monitoring the health of children education at home to ensure they receive the same service they would if attending school. This could include home educated children getting access to the full range of school nurse services from immunisations and health assessments to advice and information if requested or if identified as requiring enhanced support. Appointments can be booked at a local community clinic or nurses will visit the child's home if necessary, ensuring everyone has access to the care they need.

could include early information meetings with parents, where this is all discussed in detail and ideally a situation is agreed which results in an “opt out” of health information being shared. This would support a child focused pathway with parents which supports communication between EHE Services and relevant health services to prevent silo working and promote the health and wellbeing of children.

4.7.6. This Review highlights the need for greater communication to ensure effective working together arrangements and escalation when patterns of concern remain unchanged for children, as seen with the missed health appointments. This may have led to greater scrutiny of the situation and earlier referrals into the MASH for enquiries to ascertain what the day-to-day experiences of the children were. The aforementioned Children’s Wellbeing and Schools Bill also focuses upon a new joined-up system with the aim of “*stopping vulnerable children falling through cracks in services*”³³. A single unique identifier number is being piloted across children’s services to look at improving information sharing to better protect children’s safety and wellbeing. This new law is aimed at providing more clarity and confidence for those agencies responsible for requesting and providing information regarding individual children. It is hoped that it will speed up the process and provide a clear legal basis for sharing information on the grounds of safeguarding and promoting welfare.

4.8 Elective Home Education & Think Family

4.8.1. Finding 4: The family dynamics and parental factors needed to be recognised in relation to how this impacted on Children M’s day to day needs being persistently met

4.8.2. The decision that Children M should be home educated was likely made by the family in good faith and was in response to a safeguarding concern identified in school and growing dissatisfaction about SEND support. Mrs M, in particular, decided that her children could not be kept safe in school, and it is assumed this decision was made as to protect her children from any future likely harms. The impact of this event and family decision was hugely significant, and it likely set the scene for Mr & Mrs M feeling unable to trust in services. It prompted Mrs M to remove the female child from the primary school and home educate. All siblings once of school age, followed suit and were EHE. As previously noted, this required further exploration with both parents and would have benefitted from being revisited at times throughout the period under review to check whether the decision to keep the children educated at home remained the right one for the family.

It is likely that Children M experienced an accumulative set of harmful experiences over a period of time. Things likely changed in the family after the birth of the twins, which coincided with the onset of the COVID-19 pandemic. It would have been a challenge for agencies to spot this, given the EHE continued and the opportunities to see the children and their parents would have decreased further due to social distancing rules, and service capacity issues as a result of the pandemic. The impact of the cumulative harms led to the serious and significant incidents seen in February and March 2024. The TAF Meeting convened by SALT in January 2021, with an action for Children M to be seen, was a missed opportunity to refer and escalate matters back to CSC for a further statutory assessment of each child’s needs. The parental focus and over reliance on self-reporting continued.

4.8.3. The Review has considered what opportunities there were and what attention was paid by agencies to understand the family dynamics and consider both Mr & Mrs M’s own needs. The term

³³ The Education Hub: The Children’s Wellbeing and Schools Bill: what parents need to know Gov.uk, December 2024

'Think Family'³⁴ is a holistic 'whole family' approach and is adopted as good practice in Waltham Forest. The approach helps professionals consider and assess the needs for all adults and children involved in the family network.

4.8.4. Within the Think Family approach, all agencies working with children and their families should consider the role of fathers and men in the households, both in assessments and when providing services. Evidence and learning reviews³⁵ show fathers and male figures are often absent in recording, assessments, and care plans. The status and the role of males and new partners in the same household should be understood in terms of their potential for protection and nurturing, as well as any adverse effect they may have on the safety of the child and the mother.

4.8.5. The Learning Event pulled out the single agency information known at the time and the resultant missed opportunities to involve both parents to understand the impact of their parenting upon their ability to care for their children. From those agencies involved with the family, reflections shared included:

- a) Discussions to explore how Mr & Mrs M would have been managing given the large number of children, some of whom had additional needs. This could have included understanding their family's wider network and what support they offered or could offer
- b) Professionals to ensure an equal focus on the role of Mr M, the father in the family system and how any physical and mental health needs likely impacted on family life. There was information held by Housing and the Police regarding how Mr M was managing in the local community which could have been further explored. It is a practice reminder from this Review and the recent Rapid Review to ensure a Think Family approach and consider whether there is a dominant voice when working with parents and what this might mean for the care of the children.
- c) Assumptions likely being reached that all was well in Children M's lives, especially when one parent is vocal, so professionals' efforts and attention centred more with the adult, leading to a focus on individual children being lost. There was an over reliance by professionals to rely on parental self-reporting, particular by Mrs M who was described as convincing and credible.
- d) Concerns were flagged by the SALT regarding Mrs M's emotional/mental health, with advice to self-refer and seek support from Talking Therapies. No input or follow up was seen as professionals did not check if Mrs M had made contact.

4.8.6. Agencies are, to a large extent, dependent on the information they receive and the questions they then ask to gain a full picture of the life of a child. Where parents are appearing to be working well and, on the surface, agreeable, it is understandable to see why professionals might not look under the surface. The core concept of adopting "respectful uncertainty" is a helpful reminder and often described to encourage professionals to be curious and challenge their own assumptions, rather than accepting information at face value. This promotes a culture of critical thinking so as to actively seek out and consider all perspectives.

³⁴ A Think Family Approach ensures that professionals are responsive in addressing the needs identified, coordinating the support, and promoting joint multi-agency working between the adult and children's services to ensure positive outcomes and effective service delivery.

³⁵ ['The Myth of Invisible Men' Child Safeguarding Practice Review Panel report, Sept 2021](#)

4.8.7. Although it is now widely promoted that the responsibility is not for children to tell of the harm they are or may be experiencing whilst in the care of parents, having opportunities with a trusted adult such as a teacher and support workers in school can be helpful. Children M would not have had access to adults working in schools and this meant the opportunities to share their views, wishes and feelings would have been limited. There were also communication barriers seen as some children in the family were non-verbal, which requires professionals to demonstrate a range of communication and direct work skills.

4.8.8. The Safeguarding Partnership would have benefitted from adopting more creative approaches when Children M were seen so as to make a connection, especially with the children with additional needs, to understand what life was like at home for them. Professionals shared at the Learning Event how Children M needed access to trusted adults and safe places where they could be supported to talk openly about their lives and without fear of repercussions. These limited opportunities and barriers to communication with Children M are highlighted by one of the older children now being able to share her story and tell of how “invisible” she felt to agencies and how she created her own world with her pets as her best friends, and taking on many caring responsibilities for her younger siblings.

4.8.9. The current work underway following a previous LCSPR³⁶ regarding the identification and intervention to child neglect is noted, with the WFCSB producing a toolkit with guidance to strengthen practice in this area.

4.9 Embedding Learning from Reviews

4.9.1. Finding 5: There are limited multi-agency opportunities to learn together from statutory reviews (national and local) in Waltham-Forest and this means there is limited impact to practice strengthening in key areas, including childhood neglect

4.9.2. Similar to most Safeguarding Partnerships across England, WFSCB was keen to understand when similar practice and system themes are identified in local learning reviews³⁷ over time, and how available and effective the multi-agency learning opportunities are to support professionals to develop and strengthen their practice. This Review has therefore examined previous local learning reviews and the recent Rapid Review Child J, alongside listening to the views of frontline practitioners and managers at the multi-agency Learning Event to provide comment on this key line of enquiry.

4.9.3. The following repeat themes are seen:

- Understanding a child’s world when children are not visible to services and not in education provisions
- Improving how the lived experiences of children with additional needs are understood by agencies through observations and a range of direct work methods
- Assessing the quality of care provided to children, through the use of assessment tools
- Understanding cumulative harms and responding to risk when things change for children
- How and when professionals work together and share information to see the bigger picture
- Understanding the impact on children who have not been brought to health appointments

³⁶ [WF LCSPR Children L](#)

³⁷ [WF’s One Panel page](#) lists previous statutory reviews. Historic reviews for CSPR Children A and B and LCSPR Khalsa are available on request from the [Strategic Partnerships Unit](#).

- Additional complexities when working with large sibling groups of children
- Ensuring a professionally curious stance when working with families, which includes healthy scepticism and having difficult conversations when required
- Embedding a “think family” approach to understand parental motivations and capacity, including barriers to effective working together
- Strengthening cultural competence across agencies when working with families
- The impact of missed opportunities to escalate concerns when things do not change for children due to workforce confidence and cultures of not escalating matters

4.9.4. Views heard from those working with families suggest a cultural shift is required to ensure a multi-agency learning environment for frontline practitioners. As one senior health colleague commented, currently there is a tendency for “*silo thinking, silo working and silo learning*” in agencies. Professionals shared how learning spaces need to be available for frontline multi-agency workers to come together and build relationships, understand about each other’s roles and responsibilities, and reflect on practice issues. The Independent Reviewer sees a partnership wide appetite to learn together from what has happened to better protect children in the future, through regular learning opportunities.

4.9.5. The WFSCB have listened to the feedback and are already progressing work to build upon a more effective learning culture with organisational re-structuring of the wider Safeguarding Partnership. Partners have identified opportunities to strengthen One Panel’s role in embedding learning as part of a wider refresh of governance arrangements. The new model will improve alignment across partnership forums, with impactful learning as one of the key pillars supporting the safeguarding children partnership. The One Panel, known for its proactive membership and strong learning processes, will shift from focusing solely on serious incidents to both identifying and embedding learning. This change, along with integrating learning activities into the strategic plan, addresses gaps in the previous governance structure, where oversight and accountability for learning implementation were somewhat fragmented.

5. System Reminders when children are electively home educated

- a) The [Waltham Forest Elective Home Education Protocol](#) provides information regarding the legislation and guidance underpinning regulation of elective home education
- b) The national Child Safeguarding Practice Review Panel have published further guidance³⁸ to support professionals in practice
- c) All families electively home educating children in the Borough are sent information regarding the support available to them from agencies, particularly regarding the role of EOTAS nurses. [WF BACME Service - EHE Advice for Parents](#)
- d) If professionals have concerns about the quality of care a child receives due to parenting capacity and motivations, consider where the Quality-of-Care Toolkit would further assist in working with families, guiding professional thinking and the levels of need and intervention required.

³⁸ [The Child Safeguarding Practice Review Panel briefing - Safeguarding children in elective home education](#)

6. Practice Reminders for multi-agency professionals

- a) Where possible and if the parent so wishes, find opportunities, and take time to explore with parents the reasons for their decision to home educate. Many parents opt for home education do so not through choice, and children who are home educated are more likely to have special educational needs or to come from disadvantaged backgrounds³⁹.
- b) Be guided by Keeping Children Safe in Education 2024⁴⁰. If a parent shares their intention to remove a child from school with a view to educating at home, consider where possible a multi-agency meeting with parents and key professionals is coordinated to promote a culture of working together from the outset. This could include input from LBWF Early Years Team to share details regarding the Early Years Inclusion Pathway.
- c) When a child is home schooled, do not assume that professionals are visiting the home and monitoring their health, development, and wellbeing as currently there is no legal requirement to do this.
- d) When working with large sibling groups of children remember to be curious and take time to understand each child's experiences and needs. This may involve adopting different direct work approaches based upon learning need, gender and age.
- e) Remember to "Think Family". Identify each child and each need and understand how the needs of each person in the family affect each other.
- f) Pay particular attention to the role fathers play in the family and remember to include them in all discussions. Discuss / gain consent to liaise with Adult Services to help understand what risks and strengths they may bring to the family.
- g) Identify the wider family network to understand what additional support can be provided.

7. Recommendations for System Change

Recommendation 1: An EHE Multi-Agency Working Group to be established by the BACME Service. This Group will then provide a scrutiny report to WFSCB within 6 months of publication which focuses on the impact and effectiveness of communication and information sharing arrangements between schools, the EHE Service, 0-19 Children's Service and EOTAS. The Report should pay reference to:

- a) The benefits of a Local Criteria to be established regarding what might constitute vulnerability factors / suitability of EHE, considering child's age and ability, including whether they may have additional learning needs
- b) The benefits of the BACME Service and the EOTAS Service to develop an information sharing agreement with the 0-19 Children's Service in their area, to regularly share information,

³⁹ [Lost in Transition: The destinations of children who leave the state education system, report by The Children's Commissioner](#)

⁴⁰ [Keeping Children Safe in Education 2024](#)

with parental consent, in relation to those children who are electively home educated which is included in an updated WF EHE Policy

Recommendation 2: Public Health Commissioning to consider an increased EOTAS service which would enable all EHE children to be offered a health review. The Director for Public Health in Waltham Forest to let the One Panel Chair know within 3 months of publication of this review the outcome of their decision about this recommendation

Recommendation 3: The BACME Service to deliver the planned annual EHE Sessions by the end of 2025 with parents to increase awareness of parental rights and obligations and also provide advice on the available support services and resources in the local area. This could include future Drop-in Clinics for families if capacity allowed. The information regarding these sessions will be promoted by WFSCB in a variety of communication methods to all partner agencies to increase professional awareness of EHE.

Recommendation 4: Led by the Business Manager in WFSCB, a multi-agency Escalation Working Group to be set up (which includes operational staff) to explore the systems, practice and culture surrounding the barriers to raising practice & system issues, including use of the Escalation Policy. The Working Group will report back its findings to the One Panel within 6 months of publication with a suggested action plan to ensure more effective resolutions for children.

Recommendation 5: The Independent Scrutineer for WFSCB will ensure the Board's refreshed Governance arrangements take account of the learning from this Review and the recent Rapid Review at the following Strategic Board meeting following publication. An action plan will need to be developed by the Board to ensure there is a multi-agency structure in place which includes a refreshed training pathway to close the loop between learning lessons from Rapid Reviews and LCSPR's, improving practice and systems as identified and measuring the impact of the changes for children in the Borough.