THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

7 MINUTE BRIEFING

LCSPR: ASH

This case study is about a young person who died by suicide and was electively home educated.

June 2026

Safeguarding children who are not in school

1 About the family

Ash was a White British boy who took his own life when he was 17.

He grew up mainly with his mother in Gloucestershire following his parents' separation but later moved to live with his father and his father's partner in Surrey.

The family had experienced long-term instability. Ash's early life involved significant parental acrimony, frequent arguments in the home and multiple houses moves, including at least seven relocations and several school changes before he was 14.

2 Background

Ash was known to agencies in both Gloucestershire and Surrey over several years. Concerns included criminal exploitation, going missing, drug use and risky peer associations.

Following worrying behaviour at school and fears about peers, his parents decided to remove him from school for Elective Home Education (EHE). This decision coincided with Ash moving to live with his father in another area.

Ash had been diagnosed with ADHD through a private assessment. This was not shared with his GP or wider professionals, meaning that services were unaware of his needs or medication.

3 Patterns and practice

- EHE limited visibility and oversight of Ash's welfare and learning.
- Information shared by parents was inconsistent, and professionals did not have a clear view of where Ash was living or his educational arrangements.
- Concerns about criminal exploitation, going missing and drug-related incidents were treated in isolation, without a coordinated multi-agency picture.
- Assessments focused on single events and did not explore the cumulative impact of trauma, parental conflict, or exploitation.
- Limited direct engagement with both parents led to gaps in understanding his needs and risks.

4 Acknowledging good

- Both local authorities carried out assessments when concerns were raised, and professionals did build rapport with Ash at key points.
- Health services responded when he sought help, including ADHD assessment, although follow up was limited.
- Police acted when exploitation risks escalated, sharing information across county borders.
- Professionals noted Ash's wishes, interests and future plans, and included his voice in assessments.

5 Key learning

Gaps in education oversight masked escalating risks linked to exploitation, trauma and poor mental health.

Parental conflict can influence a young person's behaviour and emotional presentation. Practitioners must explore how this shapes risk and vulnerability.

EHE can heighten vulnerability when combined with other concerns, particularly if agencies lack accurate information about a child's whereabouts or daily care.

Strong multi agency communication and professional curiosity are essential. Assumptions about education, safety or routine must be checked, especially when children move between households or areas.

Long term disengagement from education should always prompt a safeguarding response.

6 Reflective questions

- How confident are you in recognising when EHE or absence from school increases a child's safeguarding risks?
- What steps do you take to understand a child's lived experience when they are no longer seen daily in a school environment?
- How do you ensure multi-agency information is shared promptly when children move between areas or change their education arrangements?

7 Useful resources

Find more information about safeguarding children who are not in school on the Panel's new learning hub: https://childsafeguarding.independent-panel.uk/

Read the full Local Child Safeguarding Practice Review: Ash, Gloucestershire and Surrey SCPs

Further guidance:

- Working together to improve school attendance
- Elective home education: departmental guidance for local authorities
- Improving the attendance of children with a social worker