Derby and Derbyshire Safeguarding Children Partnership

7 Minute Learning
Sara Sharif
(Surrey Safeguarding Children Partnership)

Sara's story:

Sara was born in the UK in 2013 to a Pakistani father and Polish mother. Before she was born, professionals placed her on a child protection plan because her father had a history of perpetrating domestic abuse and her mother had been a victim of domestic abuse in Poland. Throughout her life, Sara experienced persistent abuse and in August 2023, aged ten years old, she was found deceased at the family home in Woking, Surrey having sustained multiple injuries. Sara's father and her stepmother were convicted of murder and her uncle was convicted of causing or allowing her death.

Sara initially lived with both parents until her mother left the family home because of domestic abuse perpetrated by her father. Sara then lived with her mother under a supervision order which required contact with her father to be supervised and for him to attend a domestic abuse programme. In 2019, Sara's father alleged that she had been abused while in her mother's care. Subsequently, Sara moved in with her father and stepmother. The local authority assessed this arrangement and recommended to the family court that Sara should remain living with her father. The court made a child arrangements order and it was agreed that Sara's contact with her mother should be supervised.

Sara was not seen outside of the family home between March and September 2020. In 2021, after a visit to Pakistan, she started to wear the hijab to school. Professionals saw a bruise on her in June 2022 and the following week her father informed the school that he would home school Sara, but by the start of the autumn term she had returned to classes.

In March 2023, Sara's school contacted Surrey Children's Services as she had not been consistently attending. Her demeanour had changed and three separate bruises were seen on her face. After an initial assessment, no further action was taken by children's services. In April 2023, Sara's father removed her from school and she was not seen again by any professional prior to her death.

local child safeguarding practice review:

Surrey Safeguarding Children Partnership commissioned a review which found system and practice failings in how services engaged with Sara and her family and that there were several points where different actions should have been taken by agencies to protect her. The review, which was published in November 2025, concluded that Sara's death was preventable.

Sara's family members, neighbours and over forty practitioners who knew her or worked in involved agencies helped to identify six key learning areas which were outlined in the review and which informed fifteen recommendations to improve systems and practice. The key learning areas help to shape several practice principles which can support practitioners and their managers when working with children and families in circumstances similar to Sara's where domestic abuse, home education and culture are a feature. Ultimately the review urges professionals to **"think the unthinkable"** about the potential for parents to harm their children.

Key Learning Areas: Practice Principles

safeguarding processes:

referrals made to children's services did not result in the risk of abuse to Sara being identified, safeguarding processes were not followed and when her voice was expressed though a change in her demeanour, this was not recognised

Information should be gathered and analysed by experienced practitioners who have sufficient time and resources to access specialist advice, especially regarding domestic abuse, so that the presence of harm can be accurately recognised and the right support can be provided to families at the right time. Strategy discussions are an important way for agencies to share information and should be used when a child has sustained bruising indicative of physical abuse and where the explanations for the injury are dubious and inconsistent. Where possible, children should be asked directly about the injuries that they have sustained.

elective home education:

home education was used to keep Sara out of the sight of practitioners

Guidance can limit how much can be done to review parents' requests to home educate their children or to insist on seeing children at home, but where a local system is established to mitigate these limitations there should be effective management oversight to ensure that processes are followed. Records should display child's current address and where a planned home visit is unsuccessful this should be followed up.

working with perpetrators of domestic abuse:

Sara's father was a serial perpetrator of domestic abuse but the significance of this was overlooked

It is important to integrate knowledge about domestic abuse and coercive control into all child safeguarding practice including within assessments, plans and supervision. It is necessary to develop a strong understanding about the capacity of serial domestic abusers to manipulate and control victims and practitioners. The effectiveness of domestic abuse programmes should not be assumed without a thorough assessment of the perpetrator's level of engagement with the programme and a clear evaluation of how it has impacted on the safety and well-being of the children involved.

Key Learning Areas: Practice Principles

the role of the family justice system in safeguarding children:

in public proceedings supervision orders were over relied upon to protect Sara and private law proceedings did not focus sufficiently on whether her father and step-mother could keep her safe

In public proceedings, there is currently no legislative requirement for a support plan to be agreed when a supervision order is made. Therefore, it is important to consider whether such an order is sufficient to protect a child where it cannot include adequate safeguards.

In private proceedings, safeguarding children will always be promoted if the court receives the right information. Therefore, high quality reports prepared by experienced practitioners which have been quality assured by managers to ensure that there are no gaps, especially regarding a parent's domestic abuse history, should be submitted to the court. Birth parents should be appropriately represented in court and interpreters should be used as necessary to ensure that their voices are properly heard.

When children's guardians and local authority social workers have different views about the care plan for a child, this should be summarised clearly for consideration by the Family Court Judge.

race, culture, religion and ethnicity:

the impact of Sara's dual heritage was not considered and there was not sufficient exploration when she began to wear the hijab to hide her injuries

All safeguarding practice, including supervision and audit activity, should explore how race, culture, religion and ethnicity impacts on children, supported by insights from cultural experts and community organisations to help understand diverse experiences, to address disproportionality, build trust and promote inclusion.

Respecting cultural practices is important, but hesitancy about cultural and religious sensitivities should not compromise a child's safety. Where there are significant changes such as when a child starts to wear religious clothing, especially when this is unusual for their family or peers, or when they are not consistently attending school, practitioners should look beyond any sensitivities to adequately assess whether these changes indicate that the child is at an increased risk of harm.

Key Learning Areas: Practice Principles

seeking, analysing and sharing information

opportunities were missed to triangulate the information already known about the risks posed by Sara's father

It is important to gather and analyse information from various sources so that there is clarity about previous agency involvement and so knowledge can be developed about the wider family. Children can find it difficult to talk about abuse, therefore, their views, particularly about who they want to live with, should not be solely relied upon without proper consideration of current and past risk information. Information sharing procedures should be clear across all the agencies involved with a family and any barriers to sharing critical risk information should be identified and addressed.

what next?

Reflect on the practice principles in team meetings, supervision sessions and with your colleagues. Think about whether all necessary steps have been taken to act on the risks surrounding the children you work with. Would specialist advice help to improve your understanding about children's experiences especially regarding culture and religion? Do you have sufficient knowledge and understanding about the behaviours of domestic abuse perpetrators? Consider whether decisions have been made in line with expected safeguarding procedures and are they in the best interests of the child? **Where a child is home educated, think about how their safety and well-being may be affected by not being in school.**

useful resources:

Cafcass: practice guidance for when guardian's advice about the best interests of a child is different to the local authority assessment

Child Safeguarding Practice Review Panel: "It's Silent": Race, Racism and Safeguarding Children - Panel Briefing 4

Child Safeguarding Practice Review Panel: Safeguarding Children in Elective Home Education - Panel Briefing 3

Child Safeguarding Practice Review Panel: Safeguarding Children not in School

Department for Education: Children's Wellbeing and Schools (children not in education)

Derby and Derbyshire Safeguarding Children Partnership: Domestic Abuse Handbook

Derby City and Derbyshire Threshold Document

NSPCC Learning: Tipping Point: tackling the challenges in safeguarding children educated at home

Operation Encompass: help for children who experience domestic abuse

Working Together to Safeguard Children 2026