NSCP Board Briefing:
Learning from the Sara Sharif Safeguarding Review

Final report published 13th November 2025

EXECUTIVE SUMMARY

The Surrey Safeguarding Children Partnership (SSCP) review into the murder of 10-year-old Sara Sharif (published November 2025) identifies multiple missed opportunities across agencies, including failures in domestic abuse responses, front door practice, elective home education oversight, and information sharing with family courts. The review concludes that Sara's death was preventable.

Sara's case resonates strongly with NSCP's strategic priorities for 2025–27, particularly around neglect, educational attendance, and early years vulnerability. This briefing summarises the key events, presents the fully blended Key Learning and Recommendations section, and sets out the implications for safeguarding practice in Newcastle.

Sequence of Events:

From birth until her death, Sara was known to services. Professionals were actively involved at many stages – child protection plans, care proceedings, school safeguarding referrals – yet critical avenues to protect her were missed or ineffective. By August 2023, she had effectively "disappeared from view" of the system.

2010–2013: Early safeguarding intervention

Sara and her older siblings born into a family with severe domestic abuse. All children were on child protection plans from birth. Care proceedings in 2012–13 led to supervision orders, but no permanent removal.

2014–2016: Family court and contact

Parents separated. Mother and children spent time in a refuge; father's contact was supervised due to abuse history. By 2016, contact restrictions loosened despite concerns (father had not completed recommended programmes).

2019: Private law order – Sara to live with father

At age 6, after further proceedings, Sara and a sibling were placed with their father and stepmother under a child arrangements order. (The review later concludes this move "placed her directly in harm's way"). Key risk information about father's past violence was not fully presented to the family court.

2021–2023: Warning signs escalate

Sara's school and health professionals noted concerning changes — she became quieter, started wearing a hijab (neither parent did), had unexplained

bruises. In March 2023, Sara arrived at school with a large bruise on her face; she seemed withdrawn. The school referred this to Surrey Children's Services.

March 2023: Missed opportunity at "front door"

The bruise referral was downgraded (24-hour response) and handled without a strategy meeting or police input. The social worker accepted the father's dubious explanation (that hospital equipment from Sara's premature birth caused the mark) without medical checks. No one spoke directly to Sara about the injury. The case was closed prematurely, leaving Sara unprotected.

April–July 2023: Elective Home Education (EHE)

Days after the bruising incident, Sara's father pulled her out of school to be home-educated. This effectively removed her from daily professional oversight. A home visit by the EHE team was scheduled within 10 days — a critical safety check — but staff went to the wrong address due to an outdated record. The correct address was known to the school but not updated in the council system. No follow-up occurred before it was too late.

10 August 2023: Sara's death

Police found Sara's body at home in Woking after her father called 999 from abroad, saying he had killed her. She was 10 years old. Her father, stepmother and uncle had fled to Pakistan the day before, leaving five other children behind with relatives.

September 2023: Arrests

On 13 Sept 2023, after a month on the run, Sara's father Urfan Sharif, stepmother Beenash Batool, and Uncle Faisal Malik returned to the UK and were arrested for murder at Gatwick Airport.

Dec 2024: Murder trial verdict

After a hearing-two week trial at the Old Bailey, a jury convicted Sharif and Batool of Sara's murder in mid-Dec 2024. Malik was cleared of murder but found guilty of allowing Sara's death. Sentencing followed in Dec 2024 (life terms for the murderers).

Nov 2025: Safeguarding Practice Review published

Surrey Safeguarding Children Partnership released the Local Child Safeguarding Practice Review for Sara — a 70-page, detailed, multi-agency findings and learning report. This briefing draws on that report's findings, now being shared widely with all partnerships nationally.

KEY LEARNING

Analysis of information provided to this review has led to six main areas of learning. These have ultimately led to eight findings and associated recommendations. The six areas of learning are included below; Click here to read the full text of the findings:

1. The Importance of Robust Safeguarding Processes at the Front Door

The review highlights that early safeguarding responses were neither robust nor sufficiently curious, particularly during the March 2023 injury referral when bruising was not investigated thoroughly and key professionals were not consulted. Effective front-door practice requires clear thresholds, strong professional curiosity and reliable multi-agency information sharing supported by specialist expertise, especially around domestic abuse. The recommendations strengthen expectations nationally and locally by clarifying when strategy discussions must occur, ensuring high-quality triage, and improving national guidance so children with concerning injuries are never closed prematurely.

Recommendations (Front Door Practice)

- **Safeguarding Partners**: Ensure bruising that could indicate abuse always triggers a strategy discussion. Local quality assurance must routinely test compliance with statutory expectations.
- **DfE**: Strengthen national guidance to require thorough evaluation of bruising and strategy discussions where harm is suspected. Clarify expectations for inconsistent parental explanations.
- **National Child Safeguarding Review Panel**: Publish authoritative guidance on effective front-door models, including supervision and domestic abuse expertise. Build on national MASH principles to drive consistency.

2. Elective Home Education (EHE)

Sara's removal from school into EHE created dangerous invisibility, enabled by national policy gaps and local failures to follow existing good practice. The learning emphasises the need for statutory safeguards requiring children to be seen quickly, for all parents with parental responsibility to be consulted, and for EHE notifications to be triaged as safeguarding concerns when a child has a history of statutory involvement. Recommendations target both national reform of EHE legislation and local improvements to ensure swift multi-agency checks.

Recommendations (EHE)

- **DfE**: Resolve conflicts between pupil registration and EHE law; mandate parental consultation and rapid home visits where safeguarding history exists. Require multi-agency meetings for children with prior social care involvement.
- **DfE & National Panel**: Jointly reform EHE statutory guidance to address safeguarding risk where children have prior involvement with statutory services.
- **Surrey County Council & Surrey Police** (as national model): Ensure EHE notifications include police checks and always pass through the front door for triage.

3. Working with Perpetrators of Domestic Abuse

Professionals underestimated the father's history of serial domestic abuse, relying too heavily on programme attendance without verifying behaviour change. Learning reinforces the need for a whole-system approach that understands coercive control, disguised compliance and the dynamics of grooming professionals. Recommendations ensure practitioners are trained, equipped and supported to maintain an active focus on perpetrator risk.

Recommendations (Domestic Abuse)

- **All safeguarding managers & practitioners:** Strengthen understanding of perpetrator behaviours and coercive control; ensure supervision maintains clear focus on risk.
- **Local partnerships & national bodies:** Embed multi-agency domestic abuse training with specific emphasis on perpetrator behaviour and whole-system responses.
- **National & local commissioners:** Review perpetrator interventions to ensure quality and ensure feedback loops inform children's social care.

4. Race, Culture, Religion and Ethnicity

Sara's dual heritage and the cultural context of her life were not properly considered. Communication barriers for her birth mother—who was not offered consistent interpreting—reduced her involvement and voice in safeguarding and court processes. The recommendations emphasise the need for cultural curiosity, structured pathways for cultural consultation and mandatory interpreter use.

Recommendations (Race & Culture)

- **Local Safeguarding Partnerships**: Should require all agencies to develop pathways for practitioners to consult cultural experts, including community organisations.
- **All agencies**: Embed cultural exploration and challenge bias through supervision and audits; strengthen expectations for cultural competence.
- **All professional groups**: Ensure interpreters are always used in formal meetings; implement safeguards where interpreters are unavailable.
- **Local partnerships**: Benchmark local practice against national guidance on racism and safeguarding.

5. Seeking, Analysing and Sharing Information

Information about the father's past violence and the family's history existed across agencies but was not brought together. The review identifies a lack of whole family, multi agency information gathering, exacerbated by staff capacity pressures and uncertainty around information sharing rules. Recommendations focus on clarity, training and strengthening the key role of health visitors.

Recommendations (Information Sharing)

- **Local & national partners:** Clarify information sharing expectations with role specific guidance; explore digital/AI solutions for risk triangulation.
- **Local authorities & health commissioners:** Invest in health visiting capacity to ensure evidence-based work with complex families.
- **Safeguarding Partnerships:** Strengthen multi agency learning, ensuring all sectors participate in training.

6. The Role of Family Justice in Safeguarding Children

Sara's case demonstrates several weaknesses within the family justice system, including inconsistent report quality, failures in cultural awareness, lack of interpreters, and ineffective management of differing professional views. Over-reliance on supervision orders without clear plans left Sara without adequate protection. Recommendations aim to improve report quality, strengthen scrutiny, improve interpreter provision and ensure that professional disagreements are transparent to the court.

Recommendations (Family Justice System)

- **Cafcass, Local Authorities & DfE/National Policy Leads**: Strengthen guidance to ensure safeguarding letters accompany Section 7 reports; escalate cases for Section 37 investigation when appropriate.
- **Local & National Family Justice Boards**: Drive cultural and procedural reform so private law processes systematically identify safeguarding risk.
- **Courts & practitioners**: Ensure interpreters are used consistently; where unavailable, implement measures to guarantee understanding.
- **Local authorities & Cafcass**: Record and summarise professional disagreements for judicial oversight; audit compliance nationally.
- **Local authorities**: Implement national principles for supervision orders, ensuring plans address equality, diversity and inclusion.

Conclusion

The Child Safeguarding Practice Review concludes that no single agency "caused" Sara's death, but collectively, the safeguarding system "failed to keep her safe". Crucially, it notes that Sara herself demonstrated resilience and courage – she tried to care for her younger siblings and maintain a facade of normalcy – which made it even harder for professionals to see the truth without proactive efforts. The learning themes above highlight where those proactive efforts fell short, and what needs to change

Sara's murder shocked everyone, and this review recognises the urgent need to fix weaknesses in the child protection system. While the system must improve, responsibility for her death lies with the adults who harmed her. Safeguarding is complex, and even with stronger systems, it cannot prevent every tragedy — but this review shows how difficult it can be for practitioners to build a full picture when crucial information sits across different agencies.

It also reinforces the need to "think the unthinkable": while we aim to work with and support families, we must stay alert to the possibility that some parents may deliberately harm their children. This responsibility is shared across all agencies, as shown throughout Sara's story.