BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP

Sara Sharif Case – Key Findings

Introduction

This briefing focuses on the key learning points from the case of Sara Sharif's death, based on the published Child Safeguarding Practice Review (CSPR).

The CSPR, was carried out independently and had several key findings and recommendations both nationally and for local safeguarding partnerships to consider.

Safeguarding Failures at the Front Door

Initial referrals into Social Care "front door" failed to identify Sara's risk of abuse. Expected robust safeguarding processes were not followed. Information gathering and assessment was not adequately triangulated and response to the presence of bruising alongside inconsistent explanations. Sara's "voice "expressed through her change in demeanour was not heard.

Elective Home Education Risks

When Sara was withdrawn from school to be educated at home, national legislation and guidance provided a context where there was no requirement for a formal discussion between parents and professionals, even though she had a history of extensive involvement with statutory services. This context also meant that her birth mother was not consulted and there was confusion about the process for recording that she had been withdrawn from the school roll. Lack of effective management oversight also meant that the good practice in Surrey of offering home visits within 10 days was not followed.

Domestic Abuse and Assessment Gaps

Work with the father as a domestic abuse perpetrator was not properly included in childcare assessments or plans. The ongoing and repeated nature of his abuse towards his family was not fully recognised after the second set of care proceedings. Attendance at a perpetrator programme was assumed to be enough, and his claim that he had completed it was accepted without further scrutiny. There was no clear explanation of what needed to change to reduce future risk to women and children, or how any change in his behaviour would be checked.

Cultural Barriers

The Review found a notable lack of consideration given to Sara's race and culture and how her dual Polish/ Pakistani heritage may have impacted at various stages of her life. The use of an interpreter for Sara's mother was almost non existent and in private law proceedings this had a negative impact on her ability to be heard and contribute.

Information Sharing:

Work across health, social care and education did not take a consistent whole family approach or fully bring together relevant information, including previous involvement and knowledge of the wider family. This was affected by staffing pressures and uncertainty about what information could be shared, and about the roles and responsibilities of other safeguarding professionals. There were instances where individual practice did not conform with practice expected by the agency, and management and supervision systems did not provide the necessary oversight, challenge and support.

The role of Family Justice and safeguarding children in Care Proceedings and Private Law Hearings

The overall process of the private law proceedings (when it was agreed that Sara should live with her father and stepmother) did not maintain sufficient focus on the needs of the children, their cultural heritage and the ability of Father and Stepmother to provide safe care.

Within the two sets of care proceedings, the local authority changed their care plan to a supervision order and Sara remained living with her family. Supervision orders did not provide adequate safeguards; problems associated with the effectiveness of supervision orders in keeping children safe have been identified as a national issue.

Recommendations and Reflections:

As a safeguarding partnership to consider and reflect on the following:

1. Do we have robust multi agency processes in place, that are understood and adhered to by all agencies and that we have effective quality assurance processes in place which must include a requirement to hold a strategy discussion when a child comes to the attention of professionals with bruising which is suggestive of physical abuse.
2. Do we have effective management oversight and process regarding elective home education and information sharing across organisations for those children who are known or have been known to children's social are or where school have concerns regarding a child's wellbeing?
3. Does our workforce have good knowledge of all aspects of domestic abuse, including perpetrator behaviours, beliefs, attitudes and underpinning responses?
4. Are our commissioning arrangements effective and reviewed regularly on the domestic abuse perpetrator programmes and service and how is feedback gathered into how effective the programme is in safeguarding children?
5. Do we have appropriate processes and systems in place within each organisation regarding the use of interpreters to complete assessments or when this is not possible how do we ensure parents understand what is happening within the process?
6. Does our workforce known where to go or who to consult with regarding specialist services when they need additional knowledge around diverse family culture?
7. Does our safeguarding audit activity include questions around a child's culture and heritage and is this explored within day to day practice?
8. Are our social care practice standards sufficient regarding private law proceedings and supervision orders?
9. Are there any real or perceived barriers to information gathering and sharing of information across our partnership in safeguarding children and families?
10. Is our supervision and management systems within each organisation effective to provide oversight, challenge and support to practitioners?

Full Report

You can access the full Child Safeguarding Practice Review here: https://surreyscp.org.uk/wp content/uploads/2025/11/SS CSPR SSCP Report for publication 13.11.25.pdf