7-minute briefing

Sara's story

Sara is described by her mother, her family and all those people who knew her as a beautiful little girl with a lovely smile and a loud laugh. She was full of personality and it is clear that Sara stood up for herself. She was courageous and remained cheerful while living the most terrible home life with her father and stepmother. She enjoyed singing and dancing and loved her siblings very much.

In August 2023, police found Sara deceased at home in Surrey. Her father and stepmother were later convicted of her murder; a paternal uncle was convicted of causing or allowing her death. Evidence showed sustained and extensive injuries over time.

Across her life, there was extensive multi-agency involvement (children's social care, police, health, education, family courts) although ultimately the safeguarding system did not keep Sara safe. In the final year, Sara was withdrawn from school into Elective Home Education (EHE), reducing visibility and opportunities for disclosure.

6 areas of learning

Surrey Safeguarding Children Partnership

The importance of robust safeguarding processes within a system that supports parents to care for their children

Elective Home Education

Working with perpetrators of domestic abuse

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

Race, Culture, Religion and Ethnicity

Seeking, analysing and sharing of information

The importance of robust safeguarding processes within a system that supports parents to care for their children

Sara appeared to be treated differently within the household; practitioners did not sufficiently explore the "meaning of the child' (e.g. gender, non-biological relationship to stepmother).

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

Public Law outcomes twice fell short of protective plans originally sought by practitioners and contingency planning was not robust. The overall process of the Private Law proceedings did not maintain a sufficient focus on safeguarding.

Working with perpetrators of domestic abuse

The father demonstrated a persistent pattern of coercive control and grooming of professionals, deflecting allegations and shaping narratives. Responses were not consistently perpetrator-focused, leading to minimisation and drift.

Race, Culture, Religion and Ethnicity

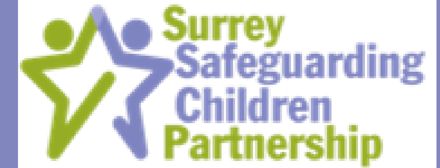
Identity factors (race, culture, faith, migration, isolation) were not consistently explored with depth or confidence. Practice must be anti-racist, culturally curious, and avoid stereotypes.

Elective Home Education

School vigilance was protective, but after EHE, professional visibility collapsed and curiosity waned.

Seeking, analysing and sharing of information

Intelligence existed across police, courts, health, and prior local authorities, but was not consistently integrated into a single working chronology. Risk decisions were sometimes made without full historic context.



Surrey Safeguarding Children Partnership

Questions to consider

These questions are prompts for all professionals working with children and families to consider during supervision

What is the **pattern of the perpetrator's behaviour** over time? How do I know beyond their account? (triangulate with police, health, school, previous LAs)

Have I **seen the child alone** and understood the "meaning of the child" in this family? Who is treated differently, and how do we know?

What changes after EHE? How have **we maintained sight** of the child?

Does our chronology show **cumulative harm** across years and places or are we reacting to isolated incidents?

What cultural/identity factors are present (race, faith, culture, isolation)? Have we sought **community or specialist advice**?

Are **escalation** routes being used?

Next steps

Surrey Safeguarding Children Partnership

Learning will be shared across the partnership using the formats below:

Webinars
Sara's story by Independent Reviewers

7-minute briefing

SSCP website and Newsletter

Learning Pathway/ Toolkit

Animated video

Current Resources

And finally….

Safeguarding is complex: It is not an exact science. Decisions are influenced by multiple factors, and system change alone cannot guarantee protection from determined harm.

Think the Unthinkable: Practitioners must remain alert to the possibility that parents may deliberately harm their children. This mindset should be embedded in everyday practice.

Holistic Understanding: Risk assessment requires a full picture of a child's life. Fragmented information across agencies and systems creates blind spots.

Shared Responsibility: No single agency can safeguard alone. Failures occurred across multiple points in Sara's life.

Further information and guidance

Sara Review - Final Report November 2025

Sara Review - Executive Summary November 2025

Working Together to Safeguard Children (2023)

Safeguarding learning and development for partners - via Surrey Children's Services Academy