Publication

Child Safeguarding Practice Review

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1 PREFACE - SARA

Sara

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. It is clear that Sara stood up for herself and she could at times be feisty. 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, showing great care for them.

Sara was born into a family who were already struggling. Her father had a history of abusing women, with a particular fascination at that time for women from Eastern Europe, and her mother had already experienced previous domestic abuse in Poland. Sara was born in the UK, was of dual Polish and Pakistani heritage and was her parents' second child from their relationship. Sara was a victim of domestic abuse from birth onwards.

As Sara's parents struggled to care for their children the local authority and the family justice system became involved, but they were unable to find a permanent solution that kept Sara safe. By the age of six Sara was living with her father and stepmother, an arrangement that ultimately led to her death. The evidence during the criminal trial, showed that her experience of living within this family was one of extreme abuse and being treated differently from the other children. Throughout this time, and until she disappeared from view to be electively home educated at the age of 10, Sara was not able to disclose the terrible abuse she was experiencing, and almost all of the time outwardly appeared cheerful and loyal to her father.

There is no single solution that will address all the factors that affected Sara, and this review has resisted simplistic responses to the complex set of circumstances of Sara's life and death. There are clearly several points in Sara's life, in particular during the last few months, where different actions could and should have been taken and the system failed to keep her safe. But it should not be forgotten that at the heart of Sara's life and death is a violent woman, and a violent man who was capable of grooming and manipulating those around him. His capacity to groom others included his family and any professionals whom he encountered. Sara's stepmother also had a troubled history. She was not open with professionals about her past and was capable of inflicting serious harm to a child in her care. Sara's father and stepmother proved to be a lethal combination, and with hindsight it is clear that they should never have been trusted with the care of Sara.

2 INTRODUCTION

2.1 This Child Safeguarding Practice Review was commissioned following the death of Sara (10 years) in August 2023. Surrey Police had received a call from father who was reporting that he had killed his daughter, Sara, at their family home. He was not there but was elsewhere. Police attended the home and found Sara in an upstairs bedroom already deceased. The criminal investigation has revealed that Sara suffered multiple and extensive injuries which are likely to have been caused over a sustained and extended period of time. Following a trial, her father and stepmother have been convicted of her murder and a paternal uncle convicted of the offence of causing or allowing her death.

2.2 As soon as they were formally notified, Surrey Safeguarding Children Partnership (SSCP) commenced information gathering. In line with statutory guidance at that time[1] this was a rapid review of initial learning. The rapid review meeting was well attended by relevant agencies, and it was agreed that a full child safeguarding practice review should start. This position was endorsed by the National Child Safeguarding Practice Review Panel[2].

2.3 Whilst action started to implement initial learning from the rapid review, the full child safeguarding practice review was put on hold as an agreed partnership decision at the request of Surrey Police. Whilst national guidance encourages reviews to continue wherever possible in parallel with criminal proceedings, in cases where there are very complex criminal investigations it is more often than not the practice for a review to start after the conclusion of proceedings to prevent the criminal investigation and trial being compromised in any way. Following the successful police investigation and criminal convictions, this child safeguarding practice review re-commenced.

2.4 The review has been led by two experienced independent reviewers who have worked with a panel of senior leaders from agencies across Surrey to gather and analyse information. The findings and recommendations of this review have been agreed with the local panel and the Surrey Safeguarding Children Partnership Statutory Partners, but the content of the final report are the findings of the independent lead reviewers.

The Review Process

2.5 The review process included:

- Date Parameters and Key lines of Enquiry for the review agreed by the Statutory Partners and Panel (please see Appendix A).
- Preparation of agency chronologies (from 2019 when Sara moved in with Father and Stepmother) and summary narrative reports of involvement prior to 2019. This is based on the directions of the Key Lines of Enquiry.
- Development of an integrated chronology.
- Consideration of court bundles in relation to all three sets of family court proceedings.
- Extensive practitioner discussions both individually and also a series of focus groups exploring issues relating to race and culture in Surrey and responses to domestic abuse.

2.6 In total over 40 practitioners who either knew Sara and her family or worked in agencies involved have contributed to the review.

2.7 Family and community interviews have taken place with:

[1] Working Together to Safeguard Children 2018
[2] The National Child Safeguarding Review Panel oversees reviews of serious child safeguarding incidents in England

- Birthmother
- Two sets of neighbours
- Two siblings (one a half-sibling and the other a full sibling.)
- Father

3 SARA AND HER FAMILY

3.1 A court order in place at the time of writing this review report quite rightly seeks to protect the identities of other children. The following outline of the family circumstances aims to assist the reader by identifying the relationships within the family and the terminology used within the report.

3.2 When Sara was born and during her early years, she lived with her birthmother, her father, one older half sibling and one older sibling. By 2019, Sara's older half sibling was in the care of the local authority and Sara and the sibling moved to live with their father and his new partner (known in this report as Stepmother). They remained there until Sara's death. Father and Stepmother had four children who were half siblings to Sara. Towards the end of her life a paternal uncle also moved to live in this household.

Sara

3.3 Sara was born a healthy full-term baby to a Polish mother and a Pakistani father. Her first language was English. From the time she was born there were concerns about the ability of adults in her family to provide a safe, loving home and she immediately joined her older sibling and half sibling on a child protection plan. This review describes the series of events which ultimately led to her moving from the care of Birthmother to live with Father and Stepmother, where she was brutally murdered.

3.4 The judge in the criminal trial commented on evidence that within her father and stepmother's home Sara was treated differently from the other children in the family. The meaning[3] that Sara had within this family was never explored by professionals but the combination of her being a girl and not the birthchild of Stepmother can now be understood as contributing to her being singled out for a campaign of abuse described by the trial judge as "torture". For Sara the reality was day to day abuse which became normalised, with her father and stepmother persuading her that she deserved the treatment being meted out to her.

3.5 Sara undoubtedly loved her sibling and half siblings very much, showing great care for them. She was identified by her school as a young carer, and she joined the school's young carers group but did not receive any help from external agencies as her stepmother did not pursue the option of referral to Surrey Young Carers.

3.6 Pictures and descriptions of Sara throughout her life show a beautiful little girl, full of personality with a lovely smile. She loved to sing and dance. Sara stood up for herself, was feisty, courageous and remained cheerful, hiding from external view the terrible abuse she experienced at home.

[3] The meaning of the child as an important issue within child protection practice was first coined by Reder and Duncan in 1993 as result of their research into child deaths and more recently the meaning of the child interview has been developed as a method of understanding parent-child relationships. https://www.meaningofthechild.org/

Birthmother

3.7 Birthmother is Polish and lived in her home country until she met Father in Poland in 2009 and then followed him to the UK. Records note that Birthmother had a troubled childhood and experienced domestic abuse in a previous adult relationship. She had two children from a previous relationship and one of those children, Sara's older half-sibling, was living with her and Sara's sibling at the time of Sara's birth.

3.8 Although Birthmother was brought up in the Catholic faith, at the insistence of Father she converted to Islam. She reverted to Catholicism immediately after her relationship with Father ended.

3.9 Although there is evidence that birthmother caused physical harm to her children, there is also evidence that she was able to maintain positive contact and work well with statutory agencies when the children were not in her care. Over time this positive potential became lost as Father continued to manipulate authorities into a negative view of birthmother and her capacity to maintain positive relationships with her children.

Father

3.10 Father was born in Pakistan and has told professionals that he had a happy childhood and a supportive family. He came to the UK to study and has described giving up his studies as he became disillusioned with the course. He has acknowledged that he then embarked on a lifestyle which included drinking and gambling, and he became interested in Polish women. Father describes himself as a Muslim, but he was hardly known to the local Muslim community and possibly only once attended the local mosque.

3.11 In 2007 and 2009 there were allegations made to the police against Father of the false imprisonment of two separate Polish women in the UK. The 2009 allegation was made by a woman who met him over the internet and flew to the UK to meet him. These allegations did not lead to him being charged with the offences, but Surrey Police subsequently informed child protection conferences about these allegations as well as other information about Father's controlling behaviour. This information is also contained within the court papers for the different sets of care proceedings.

3.12 In June 2015, health records note that Father reported low mood, stress and anxiety and was prescribed antidepressant medication which he did not take. Around this time, he started his relationship with Stepmother.

Stepmother

3.13 Stepmother originates from Bedfordshire and has described problematic relationships with her family. Reports vary, and even through the process of this review it has been hard to piece together an accurate picture of Stepmother's past (the same was the case to a certain extent for the criminal investigation as neither she nor her family spoke to the police.) Reports include the possibility of Honour Based Violence when her family disapproved of her first marriage when she was very young to a man who was from Pakistan, and later on the probability that she became involved with a man dealing in illegal drugs. During a parenting assessment in Surrey in 2016 she told the assessor that her family thought that her first husband was using her to obtain a visa. Stepmother also said that she was locked in the home by relations (not her parents) for three months, when she got the opportunity to escape, she ran away to seek refuge with her first husband where she stayed for 3-4 months. The relationship ended in 2015 when his visa application was rejected.

3.14 Also, in 2015, when Stepmother was age 21 there are records of two contacts with mental health services, the first of which was described by Stepmother during the 2016 parenting assessment. On this first occasion in April 2015, hospital records note a serious mental health episode (involving self-harming behaviour). She was assessed as needing an inpatient admission, which she agreed to. She was assessed by the hospital psychiatric liaison service. She was a voluntary in-patient for one week and then discharged to care of the community mental health team (CMHT). There is no information that she engaged with the service.

3.15 Later in April 2015, Stepmother was charged with theft offences against a female friend she had been staying with. Surrey police shared concerns around her mental health with Adult Social Care and when she was seen by the criminal justice liaison and diversion service (CJLDS) it was noted that she was ambivalent about the support offered. Stepmother was convicted of the offence and received a conditional discharge for two years.

3.16 In June 2015, Stepmother was seen in a Surrey accident and emergency department following a call to 111. She reported further serious concerns regarding self-harm spanning a seven-month period. A referral to a mental health support service was considered but declined by Stepmother. She also declined community support. The GP was faxed the report.

3.17 It was around this time in 2015 that Father and Stepmother's relationship started. Stepmother was aged 21 years and Father aged 34 years.

4 AGENCY INVOLVEMENT WITH SARA AND HER FAMILY

4.1 There was extensive involvement with Sara and her family from a variety of agencies throughout her life. Many times, professionals recognised the risk to Sara from the adults looking after her, most notably her father, and steps were taken to try and keep her safe. Ultimately these steps failed. After the local authority was unsuccessful in removing Sara from her family in two sets of care proceedings, her father was able to assume a position of power over Sara, her siblings and any professional who may have been able to challenge his motives and capacity to provide a safe, loving home. This section of the report sets out what happened at each stage of Sara's life and why at the end of her life she was killed by those who were meant to love and care for her.

4.2 The stages of Sara's life set out in this report are:

1. The period before Sara was born when there were already safeguarding concerns about her mother and father's care of her sibling and half-sibling.
2. The first set of care proceedings. Sara was born during this period, and the local authority initial care plan was for her to be removed from the family under an interim care order. The result, following the court process, was that the local authority reluctantly changed their position and she remained at home under a supervision order.
3. The second set of care proceedings. Once again, the local authority applied to the court for a care order. The final outcome of the court was that Sara and her sibling should remain with their mother under a supervision order and father should have supervised contact.
4. The period of time before Sara moved in with her father and stepmother. During this time Sara was with her mother in Hampshire. Father and Stepmother had started their own family. After the expiry of the supervision order, involvement from health and other agencies in Surrey centred on providing support in relation to this new family.
5. Father's successful application to the court for a Child Arrangements Order which allowed Sara and her sibling to live with both him and Stepmother.
6. From the Child Arrangements Order to further concerns about Sara. After the child arrangements order was made Sara gradually lost contact with Birthmother and her older half sibling. Local authority involvement with Sara ceased.
7. The school's referral to the local authority and multi-agency partnership enquiries after bruises were noticed on Sara and the explanation caused the school to be concerned.
8. Elective home education through to Sara's murder.

Birthmother and Father living together – safeguarding concerns before Sara was born.

4.3 The first time that Sara's family became known to Surrey Children's Services was in the spring of 2010 when there were police concerns about the neglect of her older half-sibling who was 3 years old at the time. There was no further action.

4.4 In 2010, Sara's sibling was born. In November of the same year Maternal Grandmother (who was living in Germany) contacted Surrey Police concerned that Birthmother had been assaulted by Father. Birthmother was in a hotel in Surrey with both her children after seeking refuge. Health records note that the children were seen by a paediatrician for a child protection medical. Sara's half-sibling was reported to have five red finger marks on their back. During the police interview Father claimed he was the victim of abuse and showed bruising on himself to the police saying that Sara's half-sibling was probably hurt when they tried to get between Birthmother and himself. This was indicative of a pattern of behaviour seen throughout the case files whereby Father deflected any allegations by blaming others.

4.5 Surrey Children's Services took immediate action by undertaking child protection (Section 47 Children Act 1989) enquiries[4] and Birthmother moved to a refuge. Father was arrested on suspicion of assault on Birthmother and her child and was bailed. The enquiries resulted in a child protection conference and both siblings were placed on a child protection plan[5]. The reason given in the records was emotional abuse because of domestic abuse, lack of permanent accommodation and poor engagement with universal child health services.

4.6 It was during this initial child protection conference that the police used the confidential section of the conference to advise the child protection chair and conference members that Father had two previous allegations against him of false imprisonment of women.

4.7 Further disclosures to Surrey Children's Services by Birthmother during the time of the child protection plan, identified Father as emotionally and financially controlling with reports of gambling. There were concerns regarding finances and extremely cramped housing. Father was reported as not having permanent residency in the UK at that time.

4.8 This child protection plan ceased in August 2011. The reasons recorded that there had been no further reported domestic abuse incidents, Birthmother was learning English, and in terms of housing the family now rented two rooms in shared accommodation.

4.9 By October 2011 there had been a further report of domestic abuse, and Sara's older half-sibling was seen at school with a bruise on their head. At first, they said that Father had hit them then later said that it was Birthmother. This led to another child protection plan. During the police interview in relation to this incident Father made a counter allegation of domestic abuse perpetrated by Birthmother. Father moved out of the home for a while but moved back in June 2012.

Summary-Analysis
Safeguarding concerns before Sara was born.

Although before Sara's birth, this period of time is significant in relation to:
- *Knowledge of allegations in respect of Father's significant abuse of women.*

[4] Section 47 Children Act 1989 places a duty on a local authority to undertake enquiries when it has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.
[5] A child protection plan is developed when a child is assessed to be at risk of significant harm, which can arise from various forms of abuse or neglect. The plan outlines specific actions and support needed to protect the child and promote their welfare.

- *Current domestic abuse of Birthmother including physical and economic abuse and coercive control.*
- *The closure of a child protection plan without any evidence that Father had addressed his abusive behaviour.*
- *The first signs of Father's propensity to turn the narrative away from a focus on his violence through counter allegations. (This developed into an ongoing pattern.)*

The first set of care proceedings

4.10 In August 2012, further serious concerns were raised during a review child protection conference about domestic abuse perpetrated by Father, injuries to Sara's older half-sibling, both parents' ability to supervise the children and the state of the property. A decision was made to explore the possibility of initiating care proceedings. In October 2012, there was a further allegation by Sara's half-sibling that Father had bitten them. In December 2012, Surrey County Council applied to the Family Court for interim care orders for the children with a care plan for separation from parents. After Sara's birth in January the local authority issued proceedings seeking an interim care order for Sara with a care plan for interim separation. As Birthmother was still in hospital the application for interim care orders was adjourned until the end of January and by the time of this hearing the local authority did not pursue the application for interim care orders and instead sought interim supervision orders, which were granted.

4.11 In February 2013 Father was convicted of theft and received a 12-month community order and to pay £1700 compensation.

4.12 There is a child protection incident on police records in February 2013 when Sara's half-sibling disclosed at school that their mother had kicked them. This resulted in a strategy discussion. When spoken to by the police the half-sibling said that Birthmother and Father had slapped them around the face but made no reference to being kicked by Birthmother. Because the half-sibling was unable to confirm exactly what had happened to them the incident was subsequently filed No Further Action (NFA). It is now recognised that more should have been done to support the half-sibling to give a full account.

4.13 The care proceedings concluded in September 2013 with a 12-month supervision order for Sara's half-sibling, Sara and her sibling. At that time in Surrey expected practice was that if children became subject of supervision orders the child protection plan should cease. The plan therefore ended following a review child protection conference in October 2013.

Summary-Analysis
First Set of Care Proceedings

During these proceedings the local authority was clear in their view that Birthmother and Father could not safely care for the children, and the initial care plan was for removal of Sara and her siblings from her parents. This then changed to an application for interim supervision orders and the final local authority care plan was for a supervision order.

The reasons given in final evidence for the change in care plan, include a review of the assessments. However, the team manager has told this review that the context for this was that local authority social workers believed that the views of the children's guardian[6] took precedence in court, and in this instance the children's guardian's view was that there was not one specific incident that warranted removal. Social workers felt very frustrated and told the review that they

[6] A children's guardian, often a social worker, is appointed by the court to represent the best interests of a child in legal proceedings, particularly those involving social services. They ensure the child's voice is heard, their needs are assessed, and that decisions made by the court are in their best interest. They are independent of social services and other parties involved in the case.

felt that their views/voice were not heard and the manager recalls sending an e-mail to a lawyer asking what evidence was needed for the children to be removed.

The team manager does recall the context at the time that the courts were reluctant to remove at the first court hearing, and then, by the time the local authority had managed to keep the children safely at home throughout the period of proceedings the view of the court after determination of all the evidence was that the situation could continue. During these proceedings that support had included daily visits over the Christmas period and then a very intensive visiting schedule which would have been unrealistic on a long-term basis.

A key issue is that this level of support/scrutiny may not continue during a supervision order and certainly didn't in Surrey at that time. In this case the supervision order for the children was not followed up with a timely robust multi-agency plan based on an assessment of risk, and all information that had contributed to the care proceedings. This is explored further in the analysis section of this report.

The second set of care proceedings

4.14 In March 2014 during a visit by a police officer to the school of Sara's older half-sibling, her half sibling made comments about Father hitting them. Teachers were unsure whether these comments related to a recent or historic incident as they had not been seen with recent injuries. This information was shared with Surrey Children's Services and there was no further police action.

4.15 A second set of care proceedings were instigated in November 2014 because Sara's older half-sibling said at school that they had been bitten on the arm by Birthmother, who was then arrested and cautioned. She admitted biting the half-sibling but said this was during a game they were playing. Sara was now almost two years old, and she, with her sibling, were taken into Police Protection[7]. An Emergency Protection Order was granted for all three children but the next day this was only extended for the half-sibling but not Sara or her sibling.

4.16 Surrey Children Services then applied for interim care orders for all three children. An agreement was reached in court that the two younger children would remain home with Father. Birthmother was to live elsewhere. A subsequent court hearing in December 2014 agreed that Birthmother would return home. At this time Sara's older half-sibling was in foster care and Sara and her sibling were subject of child in need plans[8].

4.17 As Sara's older half-sibling settled into the foster home, they made further allegations of abuse against Father and Birthmother. The social worker recalls clearly that Sara's half-sibling was very frightened of Father. During these proceedings there were further psychological and parenting assessments completed for both parents.

4.18 In May 2015, a care order was made for Sara's half-sibling by parental consent. The half-sibling subsequently thrived with the support of placements, social workers, school and virtual school. Birthmother remained in contact and fully participated in planning meetings.

[7] Section 46 Children Act 1989 (1) Where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, he may—(a)remove the child to suitable accommodation. (Known as Police Protection.)

[8] Section 17(10) Children Act 1989 states that a child shall be taken to be in need if - a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority; b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or c) he is disabled

4.19 The court determined in the interim that Sara and her sibling would live with Birthmother and after a night in foster care Sara moved to a refuge with Birthmother in Hampshire. Birthmother had told the social worker that Father was planning to take the children to Pakistan, she was continuing to experience domestic abuse and wished to separate from him. A prohibited steps order had already been made to prevent Birthmother and Father from removing the children from the jurisdiction. Father agreed not to remove the children from Birthmother.

4.20 The children's social worker had remained very worried about the risks posed by Father and set out evidence of abusive behaviour in the final social work statement to the court. In view of concerns about the capacity of both parents to provide adequate care, the final care plan of the local authority was adoption subject to the agreement of the Agency Decision Maker[9]. The view of the children's guardian at this time was that Birthmother's separation from Father was a protective factor. The children's guardian was also concerned from her observations that Sara's half sibling had a connection with Birthmother and that separation from her again would be damaging, Birthmother understood the harm that the children had suffered through domestic abuse, and the children should remain with her. After a further parenting assessment, which concluded that Birthmother could provide safe care, and having taken legal advice, the local authority amended their care plan to that of a supervision order with the children remaining with Birthmother. This was accompanied by an agreement that Father's contact with Sara and her sibling was to be supervised, and he was to attend a domestic abuse perpetrators programme. Any unsupervised contact was only to be allowed with the agreement of the local authority and Father gave an undertaking to the court not to threaten or pester birthmother or contact her except in relation to contact arrangements. This was to last until November 2016. The appropriateness of a group programme given the serious nature of Father's domestic abuse history is discussed in the section working with perpetrators of domestic abuse and finding three of this report.

4.21 Before the final hearing the children's guardian informed the local authority and the court that Father was now in a relationship with Stepmother who was pregnant.

4.22 In November 2015 the second set of care proceedings concluded with a child arrangements order granted to Birthmother with a 12-month supervision order in respect of Sara and her sibling and an agreement for Father, as outlined above. As with the previous proceedings, Sara and her sibling became subject of a child in need plan.

4.23 Another aspect of work with the family after these proceedings was the plan to keep Sara's older half-sibling in contact with their family via supervised contact.

Summary-Analysis
Second Set of Care Proceedings

During these proceedings although the original view of the local authority was that Sara and her sibling should be adopted, their final decision was changed to an agreement for a child arrangement order and a 12-month supervision order. This is explored further in section four and finding five of this report.

There was no finding of fact hearing in relation to the physical abuse of the children by either Father or Birthmother although there was an agreed threshold document in the court bundle which sets out agreed facts including that both parents had used inappropriate and excessive physical chastisement and force on Sara's half sibling. It also refers to Birthmother receiving a caution for biting Sara's half-sibling and Father also biting her half-sibling with unreasonable force causing a reddish mark.

[9] 'The Agency Decision Maker is a senior manager in an adoption agency (in this case the local authority) who makes important decisions on adoption matters, including whether a child should be placed for adoption'.

The main focus of the proceedings became domestic abuse and there was then an inappropriate over reliance within the assessments conducted on Birthmother leaving Father as a protective factor. Separation should not be seen as a protective factor in domestic abuse as there may still be control / post separation abuse and the likelihood of domestic abuse being repeated in a new relationship. It was known that Father had started a new relationship, and no action was taken to address potential risks to his new partner, whom we now know to be vulnerable in her own right. One of the key actions that could have been taken when practitioners started working with her and the family was making use of the Domestic Violence Disclosure Scheme (DVDS.[10])

The agreement accompanying the supervision order did include a recognition of the risks posed by Father but the degree to which these were mitigated depended on close monitoring and consistent reassessment of his engagement in a domestic abuse programme. It is arguable whether a child in need planning framework (the first meeting did not take place until six months after the order was made) was adequate. At the very least there needed to be a multi-agency approach to ensuring that the needs of the children were met. The issue of supervision orders is explored further in the analysis section and finding five.

The period before Sara moved in with Father

4.24 During this period Birthmother, Sara and her sibling continued to have supervised contact with Sara's older half-sibling six times a year. Practitioners working with the half-sibling recall that contact was positive and they valued the opportunity to keep in contact with their half-siblings. A family support worker met regularly with Birthmother throughout the period of the supervision order to provide both practical and emotional support and to assist Birthmother to foster positive relationships with her children.

4.25 Stepmother gave birth in 2016, and due to the previous concerns about Father a strategy meeting was held following the conclusion of a child and family assessment. A child protection conference took place in 2016. The information shared at the conference unequivocally set out risks associated with Father as a perpetrator of domestic abuse and several professionals commented that he blamed others and minimised the significance of the incidents of abuse. Other conference members accepted the history but believed it was positive that no domestic abuse had been reported against Stepmother, and she did not believe the previous accounts. The delay in Father being able to access a domestic abuse perpetrators programme was also acknowledged. Stepmother told the conference about her mental health problems, including a specific serious mental health episode of an incident of significant self-harm. The final decision was that the babies should be subject of a child protection plan. Stepmother's mental health needs were to be explored, and further assessment should take place once Father had completed a domestic violence perpetrator programme.

4.26 At that time programmes for domestic abuse perpetrators were provided by an external organisation, and the delay in accessing this programme for Father continued. At the time of the second (and final) child in need meeting for Sara and her sibling in June 2016, he had still not started a programme.

4.27 During the period of the child protection plan for the babies, a parenting assessment was undertaken by a Surrey Children's Services family support worker which was completed in November 2016. This was in line with usual practice at that time, whereby a family support worker would complete an assessment rather than the allocated social worker. (This practice changed in 2019). The information in the assessment included Stepmother's account of her mental health concerns, details of Father's domestic abuse history and a concern that he minimised the recorded incidents of domestic abuse. It also referred to a report from the domestic violence perpetrator programme (which he had now

[10] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law "enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

started) which outlined many self-reported instances of quite shocking high-risk domestic abuse, and the report was clear that he had not completed the programme or taken responsibility for his actions. Risks therefore remained. The assessment did not identify any problems in the relationship between Stepmother and Father, and in fact it was recorded that Father appreciated the fact that Stepmother kept herself, the house, and the children clean. This information was e-mailed to the social worker whose role was to complete the analysis. This analysis did not happen, and the domestic violence perpetrator programme report was not filed in the main child record. Consequently, evidence of Father's failure to complete the programme and the risks that he still posed to women and children in the relationship was not readily available for others to see.

4.28 The supervision order for Sara and her sibling lapsed in November 2016 and there was no consideration by the local authority as to whether there should be an application for this to be extended. Father was still known to be having only supervised contact with the children and Birthmother had moved from the refuge to her own property in Hampshire. Feedback from the contact supervisor regarding Father's behaviour during contact was positive, and as a result, social work input from Surrey ceased and the case was closed. There was no plan at this stage for how Father's contact might safely move to being unsupervised and how the original agreement, that this should only be with the agreement of the local authority, could be actioned.

4.29 The child protection plan for the babies ceased in January 2017, as it was believed that concerns for the children had reduced. By now it was recorded on the plan that Father was having unsupervised contact with Sara and her sibling and recorded that he "*had been assessed as being able to have his older children unsupervised".* There is no record of this arising from any assessment, although there is mention that Sara's social worker verbally agreed that unsupervised contact could go ahead. It must be stressed that no actual assessment took place. The minutes also referred to the report from the provider of the domestic violence perpetrators programme and stated that he had started attending the programme and had missed sessions due to an illness. The discussion at the conference revolved around the need for Father to complete the programme and for the local authority to remain involved until this was completed, even if the children were removed from a child protection plan. The minutes imply that he would be completing the programme in due course but there is no evidence of any such arrangement in the providers report.

4.30 The final summing up from the chair of the conference was that there were remaining concerns about the domestic violence perpetrators programme but there was unanimous multi-agency agreement that the child protection plan should end and case should close and *"it will be [the half-sibling's] Social Worker who will be asked to monitor the domestic violence perpetrator programme process and raise any concern if it is not completed*". There is no evidence that there was then any contact with the half-sibling's social worker who remained unaware of this expectation.

4.31 Sara and her siblings' case was subsequently closed to Surrey Children's Services.

4.32 In 2018, Home-Start received a referral from the nursery, which was closing, and the nursery were concerned that Father and Stepmother were not arranging alternative provision. Home-Start were unaware of any of the family history and offered support within the home, and encouragement with finding alternative nursery provision which the family were reluctant to take up. The home was described as very clean and tidy although Home-Start were aware of issues relating to over-crowding and felt that Stepmother was finding it hard to cope with her young family. She was noted to be isolated and living in a white neighbourhood with little community contact. Father, however, always seemed helpful and keen to engage with services if they could help their housing situation. Home-Start encouraged Stepmother to attend a Sure Start children's centre, but this centre closed in November 2019.

Summary-Analysis
The period before Sara moved in with Father

At this stage work with Father and Stepmother as parents of their own children gradually became disassociated from what had happened in the previous two sets of care proceedings. Most

significantly, there was insufficient analysis of the serious concerns of the local authority that had led to an initial care plan of adoption and the final decision that Father should only have supervised contact with Sara and her sibling until he had completed a domestic violence perpetrators programme. This was influenced by work in respect of the supervision order being carried out by a different social work team than the work with the child protection plan. It is not clear how much of the information within the final child protection conference was self-report from Father and how much, if anything, was factually accurate or had been triangulated in any way.

This was a period where there was an opportunity to keep a focus on Father as a perpetrator of domestic abuse and a risk to children. It was the correct approach to hold a child protection conference for the babies and the risks were clearly set out during the conference. However, the minutes of the conference indicate the need for a greater understanding by some professionals of the serial nature of domestic abuse and the likelihood that this would continue without an effective treatment programme. The added concern that Stepmother stated that she did not believe the previous allegations were true was also not understood. In this case it is arguable whether Father was suitable for a group programme due to the serious nature of the abuse, but that notwithstanding, at the very least it was vital that he complied, and completion of the programme was monitored. The decision to take the babies off the plan and then ask the half-sibling's social worker to monitor Father's compliance with the domestic violence perpetrators programme (without their knowledge) meant that the final multi-agency decision to remove the babies from a child protection plan was flawed and there was no further oversight of the care of the children within the family.

Sara living with Father and Stepmother and Private Law Proceedings

4.33 On Saturday 30th March 2019 Father reported to Surrey emergency duty team that Sara and her sibling were staying with him for the weekend and that Sara had disclosed that Birthmother had slapped her face and pulled her ear and had a scratch on her arm and bruises on her legs. Her sibling also had bruises, some of which were caused by Birthmother and the children did not want to go back to live with her. He stated that he had a court order and was asked by the emergency duty team to locate it. The children were noted to live in Hampshire.

4.34 Father took Sara to a Surrey hospital walk-in centre on Sunday 31st March. The next day he told Surrey Children's Services that he had been advised to do so by Hampshire (this was untrue). Sara was examined and although Father had described several marks on Sara, these were not observed by the health practitioners who saw her.

4.35 On 1st April 2019 the walk-in centre contacted Hampshire out of hours team to advise them that Father had visited with Sara, reporting a number of bruises caused by Birthmother hitting her. Hampshire out of hours team followed this up with a telephone call to Father who confirmed that Sara had said that Birthmother pinches and smacks her and her sibling also had bruises allegedly caused by Birthmother. Hampshire out of hours team spoke to Birthmother who confirmed that she had hit Sara, was struggling, needed support and it was better for the children if they lived with Father. After consideration by Hampshire multi-agency safeguarding hub (MASH), the case was sent to Surrey as Sara was living with Father.

4.36 On 3rd April Father was contacted by Surrey Children Services and repeated the disclosures from the children, adding that Sara had said that she had been held underwater by Birthmother as a punishment. He told Surrey Children's Services that Birthmother had agreed that the children should stay with him, he had taken legal advice and mediation had been arranged. There was no contact with the walk-in centre or information requested from the schools that the children were attending. Following contact with Hampshire an e-mail was received from them confirming that they were taking no further action. The decision of the Surrey social worker and team manager was that Father had taken appropriate steps to safeguard the children.

4.37 Home-Start became aware that Sara and her sibling had moved into the home in April 2019, Father told them this was “due to abuse”. They visited the home and recall Sara and her sibling sitting calmly and the children said they were happy with Father. Home-Start contacted Surrey Children’s Services to confirm Father’s account. Surrey Children’s Services were unaware that Home-Start were involved. Home-Start did not ask for further information but told the review that they are surprised that none of the history relating to Sara and her sibling was shared with them.

4.38 In May 2019 Father and Stepmother applied for a child arrangements order for Sara and her sibling to live with them. Sara started primary school. Stepmother showed the school the interim court order that had been made at this point and although the school were aware that there had been previous concerns in relation to Sara (they had received the safeguarding file from the previous school) they have told the review that they placed validity on the court order and that Stepmother was believed to be a safety factor.

4.39 In line with Cafcass procedures the family court advisor (FCA) completed telephone interviews with Birthmother and Father. Birthmother agreed with the current arrangements. Checks requested from the local authority were not returned in time for the family court advisor to file their safeguarding letter[11] on the 4th of July 2019 but were returned prior to the first hearing on the 9th of July. The safeguarding letter filed in court, set out clearly Father’s domestic abuse history and his self-reported information that he had addressed his anger issues. The letter advised that Sara and her sibling should remain in the care of Father and Stepmother until the local authority had completed their checks and then the FCA involvement ceased. The court hearing was led by the same Judge who heard the previous care proceedings, and the judge ordered a Section 7 report [12] should be undertaken by the local authority.

4.40 The section 7 report was allocated to a social worker in their ASYE year (Assessed and Supported Year in Employment). The team manager was not at work at the point of allocation and would not have suggested that this complex Section 7 was allocated to an inexperienced social worker. The first visit to the family was a “holding” welfare monitoring visit by another social worker as it was known that the family were going to Pakistan for a month.

4.41 This social worker does not recall seeing the Cafcass safeguarding letter and the visit to the family was therefore used to explain the process and obtain the necessary signed consent to carry out agency checks. The children were seen at this visit and there were no concerns. Throughout the process of gathering information for the report the children’s views continued to be sought and they were consistently clear that they had been abused by Birthmother. With hindsight we can now understand that these views would have been influenced by Father and fear of what might happen if they expressed any worries about their current living arrangements.

4.42 Scrutiny of past information and checks with other agencies were important to confirm the information reported by children and adults. Agency checks for the Section 7 final report included asking for information from the GP on all family members using a standard template. The GP returned a blank template (in line with their surgeries usual practice) and sent a print-out of all the contact that the children had had with the surgery. No information was submitted for the adults. The social worker was therefore not aware of Stepmother’s mental health history. The social worker did not contact Sara’s older half -sibling’s social worker and would not have been aware that maintaining any contact between the half-sibling, Sara and her sibling since they had moved to live with Father, was problematic. The team manager was concerned that the final report was not strong on analysis of the whole family circumstances, but there was insufficient time to work further on this before the report had to be filed. The team manager stated that they were somewhat reassured by the fact that the

[11] A safeguarding letter is a short report provided to the court by a Family Court Adviser in private family proceedings, outlining the outcomes of initial safeguarding checks and any child welfare concerns raised by the parties involved. This letter helps the court understand the situation and make decisions that prioritise the child's welfare.

[12] This a court ordered report prepared under Section 7 of Children Act 1989, It is a report providing the court with information and recommendations about a child

same judge was hearing the child arrangements order application as had presided over the previous care proceedings and therefore in their view knew the family and the risks associated with them.

4.43 By this time there had not been any recent reported concerns about Father and Stepmother's children and Sara and her sibling seemed well cared for. Consequently, the recommendation of the Section 7 report was that Sara and her sibling should live with Father and Stepmother and that Birthmother should have supervised contact every fortnight. The report suggested that this contact should be supervised by Stepmother, or another family member if Stepmother felt she could no longer supervise.

4.44 At the Hearing on the 8th of October 2019, the judge ordered that Sara and her sibling should reside with Father and Stepmother. Stepmother or another family member was to supervise contact with Birthmother as agreed between the parties, preferably fortnightly. The order meant that Stepmother also gained Parental Responsibility for Sara and her sibling, but importantly Birthmother did not lose it.

4.45 The order included an offer made by the local authority to provide mediation between Birthmother and Stepmother to try to assist the relationship.

Summary-Analysis
Sara living with Father and Stepmother and Private Law Proceedings

From the time that Sara and her sibling moved to live with Father and Stepmother there were at least four occasions at which the risks to children in their care could have been identified and explored.

1. *When Father contacted both Surrey and Hampshire to allege that Mother had caused physical harm to Sara.*
   There is a notable gap at this stage of anyone considering that when a child is allegedly harmed by a parent consideration should be given to a strategy discussion. Procedurally this would have been the responsibility of Hampshire as the alleged injuries had occurred in their area, but it would have been reasonable to discuss with Surrey the possibility of a joint discussion and whether child protection enquires were needed. At this point Father's word was assumed to be accurate and it was corroborated by Birthmother that the appropriate protective measure was for the children to stay with him.

2. *When the Cafcass family court advisor was required to prepare a safeguarding letter for the court.*
   The family court advisor prepared a safeguarding letter as required by the legal process. This process does not allow Cafcass to see the children, and the letter was based upon telephone interviews with Father and Birthmother. Although the letter set out Father's domestic abuse history and information about previous family court proceedings it did not recommend that the local authority could be ordered to provide a section 37 investigation[13]. There was also the opportunity for the family court advisor to refer directly to the local authority for them to consider the range of safeguarding options that they have available to initiate, which did not happen. The tone of the section 7 report did not focus on the capacity of the parents to provide safe care. The processes within private family justice proceedings are explored further in the analysis section and finding four of this report.

3. *When the section 7 report was being prepared for the court.*

[13] Section 37 of the Children Act 1989 empowers the court to direct local authorities to conduct investigations into the circumstances of a child. It states 'Where, in any family proceedings in which a question arises with respect to the welfare of any child, it appears to the court that it may be appropriate for a care or supervision order to be made with respect to him, the court may direct the appropriate authority to undertake an investigation of the child's circumstances.

The parameters of the request from the court for the section 7 report were to advise on where the children should live and contact arrangements. The review has been told that the majority of section 7 reports undertaken by the local authority do not involve the most vulnerable children and it is usual for them to be allocated to less experienced social workers, as happened in this case. More recent guidance (November 2019)[14] sets out an expectation that experienced social workers should be carrying out this task.

The safeguarding letter which had set out Father's history of domestic abuse had not been received at the start of the enquiries, although this information would have been available within the local authority files. At any time, the local authority could have asked the court to decide whether a direction should be given for a section 37 investigation, but this was not considered. Management direction at the start of the process had included a review of the files but these were not interrogated in any depth. The social worker was diligent in carrying out visits to the family and completing direct work with the children, there was however little consideration of past involvement, minimal focus on the parents beyond self-reported information and notably, no accurate information about Stepmother's past. An indication of her vulnerabilities would have been apparent from the initial child protection conference minutes in 2016.The situation was compounded by problems in the information sharing process between the local authority and the GP. This was crucial in this case as the GP records contained evidence of Stepmother's mental health history beyond the self-reported information that she had given in 2016. There was also no contact with the social worker for Sara's half-sibling who was a child in care. This information would have shown that birthmother was more than capable of managing contact arrangements positively and that father had been instrumental in cutting off contact between Sara and her half sibling. In short, self reported information was not adequately triangulated with other information known within the professional system.

Supervision did identify gaps in final analysis but there was pressure to file the report on time. Too much reliance was placed on the judge being aware of the family circumstances from previous public law proceedings. In addition, section 7 reports are not routinely scrutinised by the local authority legal team and there was therefore no double check on quality of analysis. It is important to note that at no time did the team manager who signed off the report believe that the case met the threshold for public law. A key factor influencing the team manager was that Father had already had unsupervised contact for three years without any concerns being identified.

The need for a more forensic approach to section 7 reports and improved information sharing processes is explored in the analysis section and findings four and seven of this report.

4. During the court hearing

Although this hearing was before the same judge as the previous care proceedings it should not have been assumed that the judge had retained knowledge of previous risks or that simple allocation to the same judge would prompt in depth questioning or scrutiny of the current arrangements. The previous proceedings were four years earlier and the judge would not have had access to the documents from the previous proceedings unless one of the parties or the local authority provided them to the court. To access and rely on them the judge would have needed to make a direction that those documents would be disclosed into these proceedings yet neither parent nor the author of the section7 report invited the judge to do so. The judge was impressed by the social workers report which did show good practice in the degree to which children were involved in direct work to ascertain their views. However, there were gaps in the report and there remained almost

[14] https://www.adcs.org.uk/wp-content/uploads/2024/04/Section7_Template_Resource_Pack_web.pdf

no information about Stepmother in the court arena, yet she was then relied upon to be the person managing and supervising contact between the children and Birthmother.

Birthmother was not represented in court. There was no interpreter and even though her English was passable on a day-to-day basis it may not have been sufficient for her to fully engage in the complex world of legal proceedings. Birthmother's voice became lost, she was understood to be the problem and the preferred option set out in the section 7 report was for Stepmother to supervise contact. Although Stepmother was reluctant to agree, the judge encouraged her to do so.

The consequences of the final decision of the court that Sara and her sibling should reside with Father and Stepmother were:

- *The wider professional network placed validity on the court order and assumed that because the court had examined the family circumstances, home was a safe place for the children.*
- *Stepmother became the main point of contact and was able to control Birthmother's contact with her children and the support received from outside the family.*
- *Although Birthmother still shared Parental Responsibility, she felt powerless within the system and was increasingly cut off from any decision making about her children.*

From child arrangements order to further concerns about Sara

4.46 The terms of reference for this review asked us to consider what can we learn from the cessation of formal reports to statutory agencies after Sara moved to live with Father and Stepmother and whether the cessation of reports created a false assumption that all was well? As information emerged during the review it became apparent that it was during this time that Father and Stepmother took active steps to deflect any concerns that might have arisen.

4.47 It is also important to reflect that the child arrangements order was made in October 2019 and five months later there was the first Covid-19 lockdown. This meant that Sara effectively disappeared from view for three months in the early stages of her time living with Father and Stepmother. The family were all living in a severely overcrowded flat which would have increased any stresses already in place. During the March 2020 lockdown Sara was not offered a school place as these were reserved for children with a social worker, those with an EHCP[15] or children of key workers. When the lockdown "bubbles" could be extended in June 2020, Sara was offered a place because of her living circumstances. Father and Stepmother declined the offer and Sara returned to school in September 2020. Sara's school reports, both before and after the pandemic, had noted that she consistently had struggles with her behaviour which the school put down to past trauma and a hectic home life. She was also one of a cohort of very challenging children.

4.48 It was during and following the Covid lockdown that Sara and her sibling's contact with their half-sibling also ceased even though the half-sibling's social worker took active steps to maintain relationships between them. The last direct contact took place in March 2020. Video contact was unsatisfactory for all concerned and by April 2021 Stepmother told the half-sibling's social worker via e-mail that Sara and her sibling did not want contact with their half-sibling or Birthmother.

4.49 Prior to the pandemic, Sara's school were proactive in noting that she seemed to be a young carer for her half-siblings. A young carers letter was sent home by the school in October 2019, which invited Sara to be part of the school's young carer group and to participate in young carer activities provided

[15] Education, Health and Care Plan is where a child requires additional support to help with them being able to adequately access education.

by the school. Sara's Stepmother returned the form to the school giving permission for Sara to participate. The school also gave Stepmother the application form for the Surrey Young Carers group which would have included an informal assessment of her needs and a tailored programme to provide additional support. Although Stepmother told the school she would complete the application form it seems she did not do so as there is no record of this being received by Surrey Young Carers.

4.50 Text message traffic between Stepmother and two of her sisters which was found during the police investigation shows that Father's assaults on Sara commenced in at least 2019. This is soon after she moved to live full time in his home. Some of these assaults even took place during the proceedings for the Private Law (child arrangements order) proceedings. From this period time Stepmother regularly reported to her sisters that Father would "go crazy" and beat Sara. Sometimes, she would send photos to her sisters of the bruises on Sara's body. It is clear from these that Father regularly inflicted serious violence on Sara. In one text it describes Father waking her in the middle of the night to impose a physical punishment upon her. The beatings and punishments got much worse and more frequent as time went by, leading up to her death. There were occasions noted in the text messages of Stepmother thinking that she should call the police but was told by one of her sisters to "get him to calm down".

4.51 On the 25th January 2020, Father was out with Stepmother and the children when he approached Police to report a racially aggravated public order incident. Father told officers that he had been parked outside a takeaway when the suspect had tapped on his window and told him to drink some of his alcohol. As a Muslim he found this offensive. The suspect then became angry and started shouting racial abuse, Father told him to go away. Father said that the children were crying and very scared. The suspect was arrested and given a caution. A safeguarding referral was submitted to the P-SPA[16] this was assessed as not needing to be shared with partners. A hate crime risk assessment was also completed and graded as standard. Family members present included Stepmother, Sara, and other children in the family. Consideration should have been given to the trauma the children may have experienced having witnessed the incident and ensuring this was shared with Surrey Children's Services and health partners. Since this time Surrey Police have invested heavily in raising awareness around hate crime and signposting victims/witnesses to support agencies.

4.52 Sara started wearing the hijab to school in 2021. This occurred after a visit to Pakistan, and the head teacher was proactive in questioning this change and called home to ask why this was. The head teacher was told that this was Sara's choice. Sara confirmed this and spoke about her visit to Pakistan and her fascination with the culture and food. Reasons for wearing the hijab seemed to be for cultural rather than religious reasons and she appeared very proud of it.

4.53 In June 2022 Sara's class teacher noticed a bruise under her left eye on the cheek bone. Sara said it had been caused by a younger sibling. When asked about the bruise Stepmother confirmed Sara's account and in the light of the known overcrowding and younger children in the home, the school designated safeguarding lead (DSL) believed that the explanations were consistent and there were no safeguarding concerns. No other bruising had been noticed on Sara and there would have been limited opportunity to do so as since the pandemic all children came to school already changed for PE.

4.54 A week later Father sent an e-mail to the school to say that Sara would be home schooled. This followed a progress note from the school which showed Sara working at below age-related expectations. This was followed up by a phone call from the designated safeguarding lead and Father gave various reasons including concerns about bullying and that Sara had worked well at home during lockdown. A meeting with Father and Stepmother took place during which the head teacher shared the school's concerns regarding Sara being educated at home, but Father confirmed their intention to educate at home and sent a letter to the school confirming this on 22nd June 2022. As was practice at that time, Sara remained on the school roll and a referral form was sent to the inclusion team.

[16] P-SPA is the Surrey Police Single Point of Access

4.55 The referral was received by the inclusion team on the 28th June 2022 and a telephone message left for Father on the 12th July 2022. The delay in making this call was due to staff sickness and annual leave. There was then a further delay before another telephone call to Father on the 11th August 2022 and again there was no reply, and a message was left. Father had contacted the school at the end of the summer term asking for Sara to return in September and the school had therefore not followed up any further with the inclusion team. A parental change of decision was noted by the inclusion team on the 5th September 2022.

4.56 During the school holidays, Stepmother and Father had another baby, meaning that there were now six children and two adults living in a two-bedroom flat. When the health visitor carried out the new birth visit, they had reviewed the file and noted that the previous child protection plan was closed, and Sara was no longer subject of care proceedings. The visit focused on Stepmother and the new baby, and the rest of family were in another room in the flat and were not seen. Stepmother told the health visitor that Sara and her sibling were just staying in the house, which we know to be untrue as they had been living there since 2019. Usual practice is for there to be an enquiry regarding domestic abuse at new birth visits if the woman can be seen alone. This was not possible at the first visit but when the enquiry took place at the six-week visit, Stepmother reported no domestic abuse and said that she felt well supported.

4.57 In November 2022, Sara shared in class that they were getting their home ready for her uncle who was moving in. She explained that the bedrooms were changing and all the children (apart from the baby who was with the parents) would be in the living room. The school spoke to Stepmother to check on the housing situation as there were now nine people (including the baby) living in a two-bedroom flat.

4.58 The new baby's 10-month assessment took place in clinic with a nursery nurse. Father waited outside. The nursery nurse told the review that she had a hunch that something was not right and as a result gave Stepmother information about Home-Start and playgroups.

Occupational Therapy involvement with a half sibling from November 2022

4.59 As well as health visitor involvement with the new baby a newly qualified occupational therapist was also visiting the home and school to support Father and Stepmother in caring for their other children. The occupational therapist had not seen in the records the previous history of safeguarding, including a child protection conference for Sara's half siblings. This occupational therapist recalls seeing Sara as she was keeping the younger children quiet and calm. She noted that Sara was the only person wearing a hijab but did not think this was unreasonable at the time although she has reflected that she may have been reticent to talk about it for fear of causing offence.

4.60 The occupational therapist had no knowledge of any concerns at school regarding Sara, including a referral to Children's Services in March 2023. The expectation of school leaders was that after their referral contact would be made with all relevant professionals, which may have included the OT who was visiting the family.

Summary-Analysis
From Child Arrangements Order to further concerns about Sara

During this time there was generally a lack of joined up thinking about the whole family across all professionals involved with them and this allowed Father and Stepmother to deflect any concerns about Sara. The Covid pandemic also contributed to a situation where Sara could be kept at home and when she returned to school there were several children with challenging behaviours within the classroom.

The health visitor carried out assessments in line with expectations. Stepmother denied any mental health history and previous domestic abuse history was noted with a plan for discussing this further with Stepmother at the 6–8-week review. What is apparent is that the current system within which health visitors operate does not include the capacity for a whole family assessment

and identification of the range of factors that might cause stress. Without obvious safeguarding concerns there could be no joining of the dots between the concerns of the school, the wrong information given about Sara's status within the family, the challenges in coping with young children with a range of needs, overcrowded conditions and the fact that Stepmother was living with a known domestic abuse perpetrator. This issue is explored further in finding seven.

Previous worries in school about Sara's sibling's emotional wellbeing were not known to the Surrey primary school as they had not been included within the safeguarding records. Stepmother was generally referred to as "mum" in records serving to isolate Birthmother and reducing the degree to which she was involved and kept informed of concerns relating to her children. Even though Sara was known to refer to Stepmother as her mother good practice would have been to be clear in records that this was not the case.

The initial concerns of the school regarding the intention to educate at home in June 2022 were explored by the head teacher, but there was a lack of timely follow-up by the inclusion team and the opportunity to offer a home visit as would have been expected practice in Surrey was missed. It has now been established that this was due to staff sickness and the use of inclusion officer's individual e-mails rather than a shared work box which contributed to managers not identifying the delay.

Call by school to consultation line and Multi-Agency Partnership Enquiry (MAPE)

4.61 Sara was absent from school on the 7th and 8th March 2023. The reason given to the school changed from a sore throat to vomiting. On the 9th March 2023, the head teacher (who was also the designated safeguarding lead) noticed Sara had her scarf pulled down over her face and her demeanour had changed – she was quiet and coy. The next day (10th March) bruising on her face was noticed. This consisted of three separate bruises, one to her cheek which was golf ball size, an injury to her eye and another one to her chin. The explanation given by Sara was that her sibling had punched her. The head teacher called Stepmother. The school record notes concern they had about differing explanations for the mark on Sara's chin and eye and the head teacher told Stepmother that she would need to call the C-SPA (Surrey Children's Services Front door) consultation line for advice.

4.62 The head teacher called the C-SPA consultation line and was advised to send a "request for support form" in relation to the injuries seen to Sara, even if the parents refused consent. This request for support was received at 17.20 hrs on Friday 10th March. It gave a clear account of the marks seen on Sara and concerns that her demeanour had changed. In response to the question about previous social work involvement it noted *CIN family / Welfare check 2019,* but none of the previous history that was contained within the school safeguarding files. The school assumed that C-SPA would have full access to all previous records. The request for support was triaged within C-SPA as "amber" meaning that it passed it through for a multi-agency partnership enquiry (MAPE). After a further triage by a senior social worker in the team, a social worker started enquiries on the 14th March. The expectation was that all amber rated enquiries would be completed, and a decision made about next steps within 24 hours.

4.63 Enquiries were carried out with health partners and Sara's sibling's school. The enquiry with her sibling's school was carried out by the education worker within the team and did not include explaining to them the reason for the check being asked for. The request for health checks did not include Stepmother and Sara's name was omitted from the request to health. No checks were carried out with Surrey Police and there was no conversation with Sara's school as the referrer. An e-mail to the school confirmed that a social worker had been allocated and asked the school to contact them if there was anything they wished to add.

4.64 The social worker attempted to call Birthmother but could not contact her as her phone appeared to be switched off. Father was spoken to on the telephone and said that Sara had been hit by her older

sibling. He said that he and Stepmother were "furious" about the referral and declined support. He also said that Sara had lots of marks because of the machinery she was hooked up to when born prematurely. This was false information. He also said that Sara had been asked in front of everyone whether she had been abused and she said she had not. The social worker requested that Father asked Stepmother to call the social worker, but she had not done so by the time enquiries were completed. The social worker's report was passed to the manager for sign off and the decision was no further social work action. The school was advised of this outcome.

Summary-Analysis
Call by school to consultation line and Multi-Agency Partnership Enquiry (MAPE)

The request for support from Sara's school and the subsequent MAPE enquiry was an opportunity to identify the abuse of Sara. However, although the management direction in file requested an analysis of history, the context within which MAPE enquiries were operating at the time meant that the tight timescales and volume of work meant that there was only a superficial analysis of known information. The health information gathered had gaps and this has now prompted a change in process with health practitioners within MAPE now reviewing all information for adults and children in the family regardless of it being asked for.

The manager did not ask for police enquiries to be made and lack of any enquiries with police when there is bruising on a child is surprising. Several practitioners working in C-SPA described a "proportionate approach" at that time to carrying out police enquiries and their understanding was that sibling abuse would not have warranted a request to the police for information. Senior managers were unaware of this practice and would have expected that any referral for which there was an inconsistent explanation for bruising would have resulted in police enquiries. This report of significant bruising should also have resulted in a strategy discussion where the need for a child protection medical could be agreed. This would have revealed that Father's explanation of marks on Sara from birth could have been challenged.

The MAPE process has been referred to by practitioners as a "snapshot" and the response in this case was driven by the knowledge that Sara had not made an allegation against her parents and there had been no referrals or local authority involvement since 2019. The review has been told that the social worker understood that procedures at that time dictated that only direct allegations against adult carers would lead to an automatic transfer to the assessment team where child protection enquiries would start. This was a misunderstanding as senior managers have told the review that their expectation was that the content of this referral should have prompted transfer with a request for child protection enquiries. This misunderstanding was not identified via routine supervision and quality assurance practices.

In 2023 the C-SPA service was under pressure. March 2023 was a particularly busy month with one thousand more requests for support than in the previous month.[17] Social workers responsible for MAPE's were allocated approximately seven cases every morning with the expectation that they would be with the manager for sign off at 3.30pm the following day. Meanwhile they would be allocated a further seven cases the next morning. Whilst it was clear from the electronic system that there had been extensive previous contact with the family there was no time to explore this in depth. Some practitioners have discussed the problem of seeing a clear sequence of events in the case files and have concluded that there is a need for clear and accurate closing summaries to help interrogation of past history. These summaries are particularly important where a local authority has entered care proceedings recommending that a child is removed from their parents, but the final care plan is for a supervision order.

Instead of deciding that more time was needed to analyse the meaning of the information on file, there was an overreliance on Father's account and an assumption that because the court had

[17] February 2023 there were 7724 requests and in March 2023, 8739. These then fell to 6709 in April 2023.

decided that Sara could live with him there was no need to be unduly concerned. Although senior managers have told the review that timescales could be flexible if needed, the relentless day to day need to process requests for support meant that in practice social workers would be unlikely to request additional time.

With this focus on speedy throughput, there was therefore no exploration of the wider family context, no contact with Sara's older half-sibling's social worker and no conversation with the school as the referrer. A conversation with Sara's school would have highlighted Sara's change in demeanour and the previous worries about the family's response to being asked about a previous bruise. Father's account of Sara's injuries as a baby were not checked with health colleagues and the information from Father drove the final decision to take no further action. Early help services were offered but rejected by Father

The allegation that Sara's sibling caused the bruising should have been explored in more depth. The social worker did not talk directly to the sibling's school as this task is carried out by another team member. Consequently, only basic safeguarding checks were asked for without the school understanding why these were needed and that their pupil had been named as the cause of Sara's bruises. We also now know following the criminal investigation that the sibling had shared some information about an abusive home life (for them and Sara) with a small peer group in school – they had noticed bruising too and they also knew that the sibling had to hide WhatsApp because Father would not allow it. The very positive report from the school provided reassurance rather than prompting questions as to why a child who was an exemplary pupil had caused bruising to their sister.

Discussions with practitioners have also identified a culture which seems to be wary of sharing information due to concerns about GDPR[18]. Schools have told the review that they believe that they could "get into trouble" for talking to the school of the sibling of one of their children if there were emerging concerns.

Although managers were available to social workers carrying out MAPE enquiries, managers were also known to be under pressure and the culture was one of social workers only asking for a reflective discussion with their manager in serious cases, Sara was not at the time understood to be one of those children. The review has also been told that management action to sign off multi-agency enquiries (MAPE) took place at the end of the day and due to pressure of work managers often worked during the evening. Decisions were therefore made without the ability to reflect on challenging cases with peers and check back with social workers if any information was unclear. This is not a safe approach to decision making at a crucial point in a child's journey through the system.

Although there have been significant changes to the way that C-SPA operates since 2023, the importance of the "front door" in recognising where a complex range of factors might indicate that a child is at risk of harm, and time to carry out a proper enquiry is crucial. This is likely to be a national issue and is discussed further later in this report.

From Elective Home Education through to Sara's murder

4.65 There was one further occasion when the school had occasion to be concerned about Stepmother. A member of staff heard her using abusive language in Urdu towards two younger children. A call was made to the C-SPA consultation line who said that all children in the family were closed to Surrey Children's Services apart from an older sibling who was open "but not in Surrey." This was incorrect

[18] GDPR is the General Data Protection Regulation which controls how personal information is used.

information. The advice of the consultation line was that this did not warrant a referral, and the school should speak to Stepmother.

4.66 The advice given was recorded in school records but not in Surrey Children's Services records. At that time when the two MAPE officers were busy, early help staff covered the line but did not have access to the spreadsheet, it is likely that this is the reason for the absence of a record.

4.67 Father and Stepmother had requested a meeting with the headteacher to discuss the referral that had been made to C-SPA. The issue of the abusive language was also discussed which resulted in both parents becoming very animated saying that the school could not prove that it had happened. This conversation was just prior to the Easter holidays, after which Sara did not return to school.

4.68 On the 17th April 2023, Father e-mailed the school notifying them of his intention to educate Sara at home. Usual practice would be for a school to immediately complete a form to notify the inclusion team but as this notification followed some concerns about Sara the head teacher called C-SPA again and was told to re-refer if there was a concern that Sara was at risk of immediate harm. The school then asked to see Sara and she seemed happy and well. It was also known that the family had just moved to a larger house and Sara might eventually move school.

4.69 The school then gave Stepmother the elective home education form to complete which she duly did and returned it to the office. At this point there was deviation from the usual practice of schools completing the form. This seems to have stemmed from the school's understanding that the inclusion team needed to see written confirmation directly from the parents. The request for a written notification was in line with legislation at that time[19] which required written notification from a parent that a child was receiving education other than at school in order to remove the child from the school roll.

4.70 The elective home education referral form was dated 23rd April 2023 and gave the family's new address. The school forwarded the form on 3rd May 2023 to the inclusion team. As was practice at that time (post Covid), Sara remained on roll until the inclusion team had visited and confirmed she should be removed. The policy was that this visit should take place within 10 days. There was then a delay as on 5th June the inclusion officer visited the school and told the head teacher, she had not seen the elective home education form. The inclusion officer e-mailed the school on 13thJune asking for the form again. That evening the school received an e-mail from the inclusion officer confirming that Sara could be removed from roll backdated to 17th April.

4.71 The address on the referral form sent by the school was the new address but the old address remained on the electronic system used by the inclusion team. There was an opportunity to check the address when Father was spoken to by the inclusion team on the telephone on 13th June 2023, but this was not done. Safeguarding checks took place, but this process was only to confirm that Sara was not an open case to children's social care.

4.72 The case then passed from the inclusion team to the elective home education team who attempted to carry out a home visit (to the wrong address) on 7th August 2023. On returning to the office the mistake was recognised, and a further visit was not programmed to take place until September. Sara was found deceased on 10th August 2023.

Summary-Analysis
From Elective Home Education through to Sara's murder

From April 2023 Sara effectively disappeared from view. The issues relating to elective home education at a national level are explored further in the analysis section and finding two of this report. Surrey's elective home education procedures go beyond statutory requirements by offering a home visit within 10 days of notification. Had these been implemented and Sara had been seen,

[19] Education (Pupil Registration) (England) Regulations 2006. Regulation 8(1) (d)

it is likely that the abuse of Sara would have come to light, or Father's refusal to cooperate would have undoubtably raised a safeguarding alert.

Specifically:

- *National elective home education guidance is that parents do not have to notify the school in writing whereas pupil registration guidance specifies that written notification from parents is required in order for a child to be removed from the roll of a school. Surrey elective home education policy reflects the requirements of the registration regulations. There then seems to have been a misunderstanding between the school and the inclusion team as to exactly what paperwork was required and the smooth transfer between the school and the inclusion service did not happen. At the time, two slightly different Surrey elective home education policies were published by the council and were not easily accessible to schools (this was remedied in October 2023). As well as lack of clarity over the referral process, it now seems possible that it was not clear which e-mail address documents should be sent to and what should happen in the event of staff sickness. There was then a considerable delay in the Surrey inclusion team arranging a home visit and during this period (in line with local processes that had been developed during the Covid pandemic) Sara remained on roll. Removal was then later backdated. Backdating removal from roll is unlawful and systems that developed during the Covid pandemic have now been updated.*
- *There was no management oversight or audit process that identified the delay and took steps to remedy the problem.*
- *The school correctly ticked the safeguarding box on the referral form, however, the process within the inclusion team was to only check whether the child was open to children's social care. Previous involvement was not checked and there was no interrogation of all the available information even though this was accessible. In this case the March 2023 referral by the school was not identified.*
- *Although it was noted that the school had given a different address to the one on the IT system, this was not checked. There was a clear opportunity to do so when Father was called to arrange a visit.*
- *Although Birthmother's details were on the referral sent to the inclusion team by the school, she was not contacted. She should have been informed of the intention to home educate as she still retained parental responsibility and it is likely that she would have objected as she stated to the lead reviewers. National guidance is not sufficiently clear how to proceed in these circumstances, and this is discussed further in the analysis section and finding two.*
- *The significance of elective home education as a potential safeguarding concern was not recognised within the inclusion/EHE service and the review has been told that staff responsible for elective home education have only general safeguarding training rather than training focussed on their role.*

There is an issue with recognising risks associated with elective home education for children with known vulnerabilities that sits beyond the inclusion/EHE teams. Specifically, practitioners within C-SPA need to be aware of elective home education as an additional risk factor. This has been identified in other reviews in Surrey and elsewhere and is discussed further in the analysis section of this report.

5 ANALYSIS – KEY LEARNING

5.1 The description of agency involvement with Sara and her family makes it clear that Sara's death was not caused by one specific malfunction within the safeguarding system. Numerous factors came together over many years which cumulatively laid the foundations for the severe abuse she experienced at the hands of her Father and Stepmother. Her uncle was also complicit in allowing this abuse to take place. The lead reviewers have had the privilege of time to enable us to come to this conclusion, but it is important to stress that the information set out in this report would have been

available to practitioners working with Sara and her family. However, it was not always easily accessible, as Sara's family life was complicated and information sat within different agencies and systems. This serves to highlight the challenge for practitioners in coming to a holistic understanding of a child's life both in the past and present and using this understanding to identify risk of harm.

5.2 In order to move beyond simplistic approaches to answering the question of why Sara was failed by the safeguarding system, Surrey Safeguarding Children Partnership agreed this review should use the systems framework developed and used by the National Child Safeguarding Practice Review Panel.

UNDERSTANDING EFFECTIVE RISK ASSESSMENT AND DECISION MAKING A SYSTEMS FRAMEWORK	
Systems and Processes	Practice and Practice Knowledge
Wider Service Context	Leadership and Culture

5.3 The National Child Safeguarding Review Panel's annual report for 2022/2023 (published in January 2024)[20], commented that Safeguarding partners may find this framework useful to aid their learning from serious incidents and evaluating practice more generally in their area. Using this framework has helped us to explore the interaction between the many factors underpinning Sara's death and to use this analysis as a building block for the final findings and recommendations.

5.4 As we have gathered the background information for this review in line with the terms of reference we have used this to explore:

- Did our systems and processes at a local and national level inhibit practitioners from recognising and responding to Sara as a vulnerable young child at risk of harm?
- What knowledge and skills do practitioners in all settings need to work with complex family situations, intersectionality and particularly dangerous adults who are capable of extreme manipulation and grooming behaviours?
- How can senior leaders support the multi-agency safeguarding system to work with complexity and risk of abuse, particularly where resources and time are stretched, and there are competing views as to the level of risk?
- What were the wider factors that might have affected responses including, capacity, resources, legislation and given Sara's dual heritage, what factors could have been either a risk or a protective factor?

5.5 This analysis has led to six main areas of learning which have ultimately led to eight findings and associated recommendations:

1. The importance of robust safeguarding systems across the whole partnership which includes learning in relation to the need for:
    - Experienced staff at the "front door" of Surrey Children's Services.
    - A knowledge of what constitutes significant harm or likelihood of significant harm and the requirement for a strategy discussion.

[20] The Child Safeguarding Practice Review Panel Annual Report 2022-23

- Processes and resources that enable recognition of past information and accumulating concerns that may indicate a child is at risk of harm.
- A safeguarding culture backed up by resources, that expects practitioners to balance a whole family forensic approach to identifying risk alongside family support.

2. Elective Home Education and safeguarding children. The wider legislative context combined with systems and processes, local management oversight and the required knowledge and skills to integrate good safeguarding practice within the elective home education system is important learning from this and other reviews.

3. Working with perpetrators of Domestic Abuse. This includes the knowledge and skills needed to recognise coercive and controlling behaviours, risk to women and children and the impact on children as victims of domestic abuse. The systems and processes in place to hold perpetrators to account is also an important area of learning.

4. The role of the Family Justice System. This includes learning in relation to the systems and processes linked to both public and private law proceedings as well as the practice knowledge needed to provide reports to court, and the culture established by senior leaders across organisations to supervise and support staff and work with differences of opinion. The role and intention of supervision orders within the system is key learning.

5. Race, Culture, Religion and Ethnicity. Sara was of mixed heritage with her Birthmother being Polish and her father a Pakistani national. Learning identifies the need for leaders across all partner agencies to embed a culture which expects practitioners to always consider children's identity and the impact of race and culture on the family and safeguarding practice.

6. Seeking, analysing and sharing of information. A need to ensure that information is adequately sought from those agencies that could have relevant information, and this then appropriately analysed and shared with relevant partners.

1) Importance of robust safeguarding processes within a system that supports parents to care for their children

5.6 There were numerous times in the life of Sara and her siblings that more robust safeguarding processes were needed to properly investigate the possibility that she was experiencing significant harm. For the purposes of this review and to prevent duplication, this report will focus on three of those times (other incidences can be seen in previous sections of the report.) On each of these three occasions the timeliness of multi-agency decision making needed to be much better than what happened at the time. This was particularly significant when concerns (in the opinion of the lead reviewers and the panel) reached the level that required a multi-agency strategy discussion, child protection planning and action to be taken to ensure the safety and wellbeing of Sara and her siblings. The importance of strategy discussions was also highlighted by the National Child Safeguarding Practice Review Panel's review into the murders of Arthur Labinjo-Hughes and Star Hobson[21] which stated: '*Robust strategy discussions would have allowed professionals to put all of the evidence together, interrogate it, challenge each other's perspectives, and agree a coordinated and strong response.' 'All Safeguarding Partners should assure themselves that: Robust multi-agency strategy discussions are always being held whenever it is suspected a child may be at risk of suffering significant harm.'*

5.7 **The first of the three incidents being highlighted** was in 2019 when Father disclosed to Surrey and Hampshire Emergency Duty Teams (EDT) that Sara had said that Birthmother had hit both her and her sibling and she did not want to return to live with Birthmother. As noted in section three of this report, Father took Sara to a Surrey hospital walk-in centre with bruises. Examination found marks

[21] *The Child Safeguarding Practice Review Panel (2022) Child Protection in England*

which were noted to be superficial, but this finding should not have precluded a referral to a paediatrician for a community child protection medical since there had been a direct allegation of physical abuse.

5.8 Although both Surrey and Hampshire out of hours social work teams were made aware of this incident, they too did not consider it warranted the use of safeguarding procedures. The police were not informed and there was no proper investigation as to what had happened. The need for further consideration should have been triggered not only by the allegations of physical harm but also because the previous decision of the family court was that Father should only have supervised contact, including the fact that the children he had with the Stepmother had been on a child protection plan in the last two years. This decision to leave the children with him is hard to understand although it is known that Father was very persuasive and the assumption was made that Birthmother was the aggressor, and it was in the children's best interest to stay with Father.

5.9 **The second incident** was in June 2022, when Sara's class teacher noticed a bruise under her left eye on the cheek bone which Sara had said had been caused by her sibling. When the school designated safeguarding lead at Sara's school queried this with Stepmother, it was only a few days later when Father sent an e-mail to the school to say that Sara would be home schooled, giving reasons which included bullying and that Sara had worked well at home during lockdown. The two events were seen in isolation and the reasons given for the bruises were seen as reasonable by the school and therefore not referred. This is understandable on the part of the school since the rights of parents to educate their child at home are ingrained in our system. The need to consider elective home education as a potential safeguarding risk especially where children have additional vulnerabilities is discussed later in this analysis section. This incident highlights the urgent need for our systems and processes to balance the rights of parents to educate at home with effective safeguards for vulnerable children and for schools and other professionals to feel confident to implement a multi-agency safeguarding response whenever a request for elective home education coexists with other concerns that a child is suffering significant harm.

5.10 **The third incident** was in March 2023 when Sara was absent from school for two days and the reason for absence changed from having a sore throat to vomiting. The details surrounding this incident are set out in section three above.

5.11 It was notable that when Sara returned to school her demeanour had changed to one of being quiet and coy and she pulled her hijab down over her face. When significant bruises were noticed the next day, the designated safeguarding lead called Stepmother and when not satisfied with the explanation given, they made the correct decision to call the C-SPA (Surrey Children's Services Front door) consultation line for advice. The consultation line also made the correct decision to advise the designated safeguarding lead to send a referral, (known in Surrey as a request for support) even if the parents refused consent. The explanation given by Sara for one of the bruises was that her sibling had punched her.

5.12 The request for support form gave details of school's concerns, including Sara's explanation.

5.13 Instead of the concerns about bruising triggering a strategy discussion, the multi-agency partnership enquiry (MAPE) did not include enquiries with the police. The driver for this response was not workload but a team culture which aimed to take a proportionate approach to requesting such checks and did not utilise the advantages of co-location in a multi-agency hub which should result in better information sharing. As outlined in section three of this report, there was a disconnect between the expectations of senior managers and frontline staff at that time and this was not picked up via management, supervision and quality assurance systems. Senior managers expected such referrals would include at a minimum police checks, whereas practice within the team was that only where a child had made a direct allegation against an adult would police checks and consideration of transfer to the assessment team for a strategy discussion be required. What is clear is that there is no bruising protocol (other than for non-mobile babies) and custom and practice diverted from the established knowledge about what needs to happen to keep children safe.

5.14 It is the view of the lead reviewers that any apparent non accidental injury should prompt a strategy discussion involving Surrey Children's Services, Police, Health and the schools involved. Even if accepted that one of the bruises may have been caused by her sibling (we now know this wasn't the case and injuries were caused by Father) there were younger, equally vulnerable children in the household. A Section 47 enquiry, including a safeguarding medical examination, would have then been the presumed outcome if a strategy discussion had taken place.

5.15 This issue is wider than Surrey, and social workers who have now moved from Surrey to other local authorities have told the review that this would be a common response in many areas. In addition, the National Child Safeguarding Review Panel have expressed concerns in relation to the lack of use of section 47 strategy meetings and inquiries: '*Local reviews continue to highlight issues about the effectiveness of such meetings, including who attends (with health colleagues sometimes not present), and the robustness of actions that follow. In Child Protection in England, 2022 and our recent Annual Report, we have drawn attention to what we believe are national systemic difficulties in how strategy discussions, section 47 enquiries and child protection planning are undertaken*.' Sara is another child who would have benefited from the consistent application of effective use of safeguarding procedures.

5.16 The need to understand better how C/P-SPA/MASH teams operate has been recognised at a national level with recent research reports being commissioned by Police[22] and the Department for Education[23]. The later report identifies that MASH services across England operate on a continuum from risk assessment through to needs assessment and service planning. The Panel for this review has discussed the possible influence of a shift in Surrey to the Family Safeguarding Model with a focus on engaging with families and using a strengths-based approach to effect change. It is important to stress that this model does not exclude recognising when a child is at risk of harm and instigating proper procedures. In fact, this would be expected practice. The approach of working alongside families, understanding where the barriers might be to engaging with help and seeking to address those barriers through strong relationship-based practice will be the best approach for most families. However, in order to protect children from harm, this does also need to be based on a forensic evidence-based approach which moves beyond self-reported information. The routine triangulation of information, especially at the front door of children's services will be important if we are to be able to identify parents who are capable of inflicting serious harm and are intent on evading the scrutiny of authorities. In this case a more forensic approach which integrated an assessment of risk would have triangulated the self-reported information from Father, including the (wrong) information about Sara having marks from equipment used post birth.

5.17 The issue for Sara was that the response at the front door did not take this thorough forensic approach. The key driver was *not* the Family Safeguarding Model but a front door service which was managing a high level of demand and the emphasis within the team had become throughput and meeting timescales. There was a loss of focus on good safeguarding practice and limited time to stop and reflect. In this instance the quality of the multi-agency partnership enquiry (MAPE) fell short of what was expected by senior managers in Surrey. Specifically, the review has heard that the pressure of work in C-SPA was such that a detailed review and analysis of information was not possible. Interrogating information within the social work records was problematic and although it was possible to identify that there had been considerable involvement there was not time to explore the history in detail or to take a whole family approach to gathering information. This could have included talking to the social worker for Sara's half sibling who was in the care of the local authority and considering the information gathered for the child protection conference for the children of Father and Stepmother. This would have given a more complex picture than was immediately apparent. The emphasis at that time on throughput and meeting timescales meant that the practice culture did not encourage practitioners to identify complex cases where more time was needed to assess.

[22] https://www.vkpp.org.uk/assets/Files/MASH-guiding-principles-Apr25.pdf
[23] Foundations: What works centre for children's and families (June 2024) evaluation-of-multi-agency-safeguarding-hubs.pdf

5.18 Following a Joint Targeted Area Inspection in March 2023 Surrey safeguarding partners invested considerable resources into improving practice within the C-SPA. Sara's murder sharpened the focus of these improvements, which included being clear across the partnership that consent should never be a barrier to safeguarding children. There is clarity that an effective front door is one that is responsive to new concerns about the welfare of children, identifies risk and recognises the different levels of intervention required to improve outcomes for children and reduce the likelihood of harm.

2) Elective Home Education

5.19 Before Sara was murdered, the local authority had been notified that she was being educated at home. There had been a previous request a year earlier although on this occasion the family changed their mind and Sara returned to school.

5.20 The sequence of events both in relation to the initial notification, and the notification in 2023 outlined on pages 21-23 of this report, took place following a significant increase in the numbers of children being educated at home as a result of the Covid pandemic. As a local authority Surrey had improved their policy and went beyond other local authorities in expecting the inclusion team to offer a home visit within 10 days of notification. However, in Sara's case, both times they received notification of intention to electively home educate the local processes were not followed.

5.21 On the first occasion staff sickness and annual leave resulted in delay and Surrey are now ensuring that there is sufficient management oversight to identify where this may be a problem.

5.22 The delay in relation to the second request was linked to a misunderstanding between the inclusion team and the school about the way in which notifications should be received from parents and sent to the inclusion team. Surrey Education has identified that at the time there were two policies situated in different areas of the website, neither of which would have been easily accessible to schools. The need for clear school focused guidance has been acknowledged. However misunderstandings sat within a national context of lack of congruity between the Department for Education elective home education guidance which does not require parents to notify the school of their intention to home educate and the pupil registration regulations which state that the school must remove a child from roll when a proprietor has received written notification from the parent that the pupil is receiving education otherwise than at school. This led to an undue focus on process and the attempt to work within the regulations led to debate and misunderstandings between the school and inclusion team which resulted in a delay in a deregistration visit taking place and Sara being seen in her home environment. This was then compounded by internal systems and individual practice decisions which meant the intended visit was to the wrong address and the visit was rearranged to take place on a date which fell after her murder.

5.23 There can now be no doubt that Sara's Father and Stepmother used home education to keep Sara hidden from view in the last weeks of her life. In English law, under section 7 of the Education Act 1996, the responsibility for a child's education rests with their parents. Parents may choose to send their child to school or to educate them at home, and for many children the decision to home school is a positive choice which enables them to thrive. The national challenge is to establish a system which celebrates and supports good home education whilst safeguarding children who do not thrive, or like Sara are abused and hidden from view.

5.24 At the time of Sara's murder, the legislation and guidance[24] supported a process which:

- Required schools to notify the local authority if a parent informed them of their intention to remove a child from school to home educate.
- Encouraged local authorities, schools and other key professionals to work together to coordinate a meeting with parents/carers where possible.

[24] Elective home education: departmental guidance for local authorities EHE_guidance_for_parentsafterconsultationv2.2.pdf

- Required parents to provide a "suitable education" but did not give the local authority a legal power to monitor home education on a routine basis. If the local authority was not satisfied that the child was receiving a suitable education, they could commence the statutory process for the issuing of a School Attendance Order.

5.25 This process had limitations:

- There was no detailed definition of what constituted a suitable education.
- The process did not allow the local authority to insist on visiting the home and speaking with the child.
- There was no legal duty for parents to discuss their intention with the school and no requirement for the school to respond. Although meetings at the point of decision to educate at home were encouraged they were not mandated and a review of child safeguarding cases by the national child safeguarding review panel found that: *The reviews considered by the Panel did not provide clear evidence that schools, parents, and the local authority were routinely working together when parents had expressed their intention to educate their child/ren at home, and as recommended in national guidance.*[25]
- There was no clarity within elective home education guidance as to how to work together with separated parents and how to respond if one parent with parental responsibility disagreed with the other parent's intention to home educate.

5.26 Surrey's elective home education policy reflected the national picture of a system which aims to both support home education and keep children safe from harm. The result was confusion rather than clarity. One set of regulations[26] required written notification from parents that a pupil was receiving education otherwise than at school in order for them to be removed from the roll for this reason. Schools were required to notify the local authority when a child is removed from roll, but parents were not required to notify anyone of their intention to home educate. Surrey went beyond the requirements of statutory guidance by expecting a home visit to be offered within 10 working days, but there was an unacceptable delay in the inclusion team offering a home visit due in part to a discussion with the school as to whether written notification was required and what this looked like.

5.27 The tensions within the guidance in its aim to support both home education and safeguarding are also evident in meetings at the point of elective home education being encouraged but not mandated. Elective home education practitioners are expected to identify when a child may be at risk of harm and use safeguarding procedures but are unlikely to have seen the child. A focus whether the child is *currently* subject of a child protection or child in need plan excludes children who may have other indicators of vulnerability including past concerns.

5.28 In relation to separated parents, the school notification did give Birthmother's details but there was no contact with her by the inclusion team. Government guidance for schools and local authorities states[27] *In the case of separated parents, case law states that all those with parental responsibility must be consulted before important decisions are made, such as removing a child from their school, when they should leave the school or which new school they should attend.* However, there is no statutory obligation on a school to notify one parent if the other decides to remove their child – that responsibility rests solely with the separated parents. Guidance goes on to note that nonetheless*, the child's welfare is paramount, so, if a school is aware that parents are separated and one parent decides to remove their child, staff may wish to ask that parent if the other has been informed and has agreed to this. A school should avoid becoming involved in parental conflicts. If parents are unable to agree lines of communication between themselves on issues involving their child, they may wish to seek independent legal advice and explore other options.*

5.29 Whilst in the majority of situations where parents disagree this will not be associated with safeguarding concerns, there should be consistency of approach across local authorities. This should

[25] CSPRP_Elective_Home_Education_Oct_2024.pdf
[26] Education (Pupil Registration) (England) Regulations amended 2016. Regulation 8(1) (d)
[27] Understanding and dealing with issues relating to parental responsibility - GOV.UK

ensure that all those with parental responsibility are informed, what action to take when parties do not agree and the impact of this on the child. Sara's mother had no idea that she was no longer in school and has told this review that she would have objected if she had been informed.

5.30 The situation in Surrey also reflects national findings that safeguarding knowledge and skills within local authority elective home education teams need to be strengthened and safeguarding practitioners need to be more aware of the additional risks associated with elective home education where children are already vulnerable. At the time Sara was referred to C-SPA, asking about elective home education was not routine (this has now changed), and there was a notable absence of GPs and other health professionals being made aware that a child was being educated at home. It is positive that as a result of Sara's murder, Surrey have now strengthened communication with GPs. There is automatic notification of children/families registered with the GP practice if C-SPA have received a safeguarding referral and this would now include information about elective home education.

5.31 The measures in the forthcoming Children's Wellbeing and Schools Bill (2025) contribute to improving the interface between the rights of parents to educate at home and safeguarding children. However, the key change of a national register of children educated at home would not have protected Sara. The Local Government Association makes an important point in their critique of the Bill noting that: *The Bill contains several measures around elective home education. We recognise that the vast majority of those who home-school their children are doing an excellent job, however we also know that home-schooling has been a factor in a number of cases where children have come to serious harm. Measures in the Bill around "children not in school" register [Clauses 25-26] are welcome, however we continue to call for powers and resources for councils to speak to children directly, to check that they are safe and being taught a suitable education. Similarly, requiring parents to obtain the consent of the council to home educate if their child is subject to a child protection investigation or under a child protection plan [Clause 24] is helpful, but will only apply where councils already have contact with a child and their family. Councils can better protect all children if they have powers to see all children where they are being home educated.* [28]

5.32 Whilst it is important that this review does not become a catalyst for curtailing the freedom of parents to educate their children at home as is feared by the home education community[29], it is also important that Sara's legacy is a much more coherent system which provides adequate safeguards for all children through:

- Clear systems and processes notifying the local authority when children are educated at home.
- Multi-agency plans to support parents and safeguard children where children have been subject of public law proceedings, child protection or child in need planning at any time in their childhood.
- Legal powers to see children at home and hear their views.

3) Working with Perpetrators of Domestic Abuse

5.33 There were numerous times before Sara was born and throughout her life, that the seriousness and significance of Father as a serial perpetrator of domestic abuse was overlooked, not acted on and underestimated by almost all professionals who became involved with Sara and her family.

5.34 The instances of the false imprisonment of two separate women in 2007 and 2009 were always shared by the Police at child protection conferences and were part of the court bundle for the 2015 care proceedings. The reports of physical abuse on Birthmother by Father, which were made to

[28] https://www.local.gov.uk/parliament/briefings-and-responses/childrens-wellbeing-and-schools-bill-second-reading-house
[29] https://www.westcountryvoices.co.uk/the-childrens-wellbeing-and-schools-bill-an-attack-on-home-education-and-parental-rights/

Police and Children's Services, are also within the case files, but Father's coercive controlling behaviour was not recognised or acknowledged anywhere nearly as much as it should have been. It is accepted that the police were never able to prosecute him for offences connected to domestic abuse but nonetheless this didn't minimise his known risk. This risk was to both women and children, with research and other reviews showing a correlation between violence towards women and the abuse of children.[30]

5.35 'Nineteen Child Homicides" report published by Women's Aid[31], tells the stories of nineteen children who were intentionally killed by a parent, who was also a perpetrator of domestic abuse, through unsafe child contact arrangements, informal and formal. The report reviewed relevant Serious Case Reviews for England and Wales, published between January 2005 and August 2015 (inclusive). It uncovered details of 19 children in 12 families who were killed by perpetrators of domestic abuse. All the perpetrators were men and fathers to the children that they killed. All the perpetrators had access to their children through formal or informal child contact arrangements. As well as 19 children killed, the perpetrators also attempted to kill two other children at the time of these homicides, they also killed two mothers. Our focus is on children, like Sara, but in some of these cases women were also killed. The blame for these killings lies with the perpetrators. However, this review also concludes that these cases demonstrate improvements that need to be addressed to ensure that the Family Court, Cafcass and children's social work and other bodies actively minimise the possibility of further harm to women and children following separation.

5.36 Domestic Abuse Stalking and Honour Based Violence (DASH) risk assessments were completed following the known Domestic Abuse from Father to Birthmother and identified standard risk. At that time this meant that there would have been no referral for a Multi-Agency Risk Assessment Conference's involvement (MARAC).

5.37 Following the 2015 care proceedings Father was instructed to attend a domestic violence perpetrator programme. At that time it seems that the group programme was delivered by an external organisation, and it wasn't until many months after the start of the supervision order that Father actually attended any sessions. There is no evidence of an assessment as to whether a group programme was appropriate for Father, given the extensive and serious nature of his abuse of women and research evidence[32] suggests that group programmes may not achieve positive outcomes for certain categories of perpetrator. The system in Surrey today is that where children are subject of a child in need or child protection plan, domestic abuse intervention programmes are usually individual and delivered by specialist practitioners within the Family Safeguarding Team. The feedback loop into children's social care is therefore strengthened. However, the review has been told that Father may not have been eligible for this intervention as programmes are not delivered where a programme has been mandated by the family court. The premise of these programmes is that the person is motivated to change, and this is unlikely where they have been directed to undertake a treatment programme. This potential gap in provision if programmes are directed as part of a supervision order is explored further in finding three.

5.38 A domestic violence perpetrator programme progress report was sent to Surrey Children's Services and makes quite shocking reading. Father admitted to extensive and wide-ranging domestic abuse and our knowledge of domestic abuse perpetrators must lead to the conclusion that he would have seriously minimised this. He only attended eight out of the programme's 26 sessions and the report states that there is not enough evidence that the Father had changed his behaviour as a domestic abuse perpetrator. Although the family support worker appropriately commented on this report in the parenting assessment for the child protection plan for Sara's half-siblings, its significance then became lost within the system. The report should have been sought or enquired about for the 2019

[30] McDonald ,R, Jouriles, E, Rosenfield, D, Corbett-Shindler, D. (2011) 'Predictors of Domestically Violent Men's Aggression toward Children: A Prospective Study' *J Fam Psychol*. Feb;25(1):11–18.

[31] Child-Homicides-2025-Web-Final.pdf

[32] Renehan, N. and Gadd, D. (2024) For Better or Worse? Improving the Response to Domestic Abuse Offenders on Probation, The British Journal of Criminology.

Private Law proceedings, but it was not, and it was not easily accessible within children's social work files. In addition, the Cafcass family court advisor when preparing the safeguarding letter did not consider or analyse Father's response to the programme even though his attendance had been stipulated within the written agreement at the conclusion of the previous public law proceedings.

5.39 There seems to have been no system that routinely obtained feedback from perpetrator programmes and there was no clarity as to the consequences for perpetrators such as Father who minimised and also failed to complete the programme. Father was able to lie about successfully completing the programme, a position he maintained when he spoke to the lead reviewers. Even if he had attended, simply attending the programme would not be a reliable indicator of positive progress without other evidence of change being present.

5.40 There was an over reliance by professionals in 2015 on Birthmother leaving Father and this was seen as a protective factor. Separation should not be seen as a protective factor in Domestic Abuse as there may still be, and often is, control / post separation abuse and the likelihood of Domestic Abuse being repeated in a new relationship. It was known that Father had started a new relationship, and no consideration was given by professionals to the potential risks to his new partner who was clearly vulnerable in her own right. Information about his potential for Domestic Abuse was not shared with people involved in offering support to Father and Stepmother very soon after the conclusion of these proceedings. Cafcass has already made serious and determined steps to improve domestic abuse practice including issuing their domestic abuse policy, which will strengthen their response to domestic abuse within private law proceedings in the future.

5.41 The messages between Stepmother and her sisters present a picture of a home where physical domestic abuse was prevalent and Father's coercive controlling behaviour was a daily occurrence for Stepmother, Sara and her siblings. The messages reveal that Stepmother did try to leave and consulted a solicitor. The 'Trust Project' is a culturally competent project that has been developed by Surrey Minority Ethnic Forum to help survivors of domestic abuse within ethnic minority communities who can experience additional barriers to seeking support. Wider knowledge of this project is needed.

5.42 One of the issues that has been raised with the lead reviewers is the lack of multi-agency Domestic Abuse training across the safeguarding partnership for the children, adults and safer community's boards, particularly in respect of perpetrator behaviour. The evidence from this review highlights that practitioners carrying out any assessments involving children need a good up to date knowledge of domestic abuse and coercive control. This requires further exploration by those that commission training locally. The police DA Matters training for officers is highly regarded and consideration could be to make this a wider training offer, or a more appropriate version of it. This should include ensuring that practitioners are aware of domestic abuse legislation and civil powers. Alongside this, information from this review shows that practitioners need to move on from an approach which sees separation as a protective factor. Assessments and recommendations must include an analysis of police information, consideration of how the separation is happening (given that this may be part of the perpetrator's control of their victims), understanding post separation abuse and of the likelihood of a perpetrator repeating this abuse in a new relationship.

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

5.43 The role of the Family Justice system was significant in Sara's life and the learning in this section of the report is taken forward in the final findings and recommendations of this review. The key areas for learning are:

- The management of differing points of view between children's guardians and social workers and how the court reaches a decision about the final care plan in public law hearings.
- The use of supervision orders to monitor and intervene where appropriate.
- Professional understanding and management of child contact, domestic abuse and parenting.
- Safeguarding children within private law proceedings

The final care plan

5.44 The first and second set of care proceedings (public law) have highlighted concerns that local authority social workers (not just in Surrey but also in some other areas of the country, accepting that this is not in all areas of the country) have in relation to their involvement in Family Justice cases. The lead reviewers were told by social workers and team managers that they feel stuck in the face of an alternative view from the children's guardian which they perceive to be held in higher regard by the court. This perceived culture is one where they feel that the status of local authority social workers is on balance less regarded by judges and the court than the advice given to the court by children's guardians and experts. This needs further exploration in the light of case law which required the court to give reasons when departing from the recommendations of the children's guardian.

5.45 This local view and the lead reviewers' findings are supported by a study carried out by Community Care,[33] albeit a small survey of 185 social work respondents found that, *'More than half (55%) of respondents said they feel their professional judgement is 'never' or only 'sometimes' respected by judges and lawyers.'* The study also stated that. '*The survey also revealed differences in the perceived status of social workers and guardians in court. Most respondents (54%) said social workers had a 'low' or 'very low' status in court, whereas 73% considered guardians to have a 'high' or 'very high' status.'*

5.46 Sir Andrew McFarlane, president of the Family Division of the High Court for England and Wales, when speaking in March 2025 on The Relational Social Work Podcast [34] noted that the professionalism of social workers must be respected in court. He made further comment, *'I have always been very keen to support social workers and all they do. In many ways it is a thankless task. You are criticised if you do one thing and criticised if you do another.'* He also said, '*It is very easy for social workers to feel disempowered and lacking in confidence when they enter the courtroom and they shouldn't. They are professionals, they are expert in social work and should be regarded as that.'*

5.47 This review has heard from social workers that their perception is that if there are differing views between the local authority and the children's guardian the court will find in favour of the guardian. This has led to a culture within this and a number of other local authority areas acceding to the guardians' position at the later stages of proceedings. We must reiterate that this is not the case throughout all judicial areas of the country.

5.48 At one stage in the second set of proceedings, the children's guardian commented that the parenting assessment and psychological assessment supported Surrey Children's Services care plan for removal. However, the children's guardian later on in the proceedings felt that the evidence did not contain any risk assessment in relation to physical abuse of the younger children, including Sara. The children's guardian conducted further enquiries and advocated the return of the children to Birthmother's care pending final decisions because she felt that parents were 'not in danger of reconciling'. Her view was that the mother's separation from the father was a protective factor and that she had insight into the harm that the children had suffered through the domestic abuse. A further psychologist assessment ,late in the proceedings, agreed with this finding.

5.49 *'The way in which the Children's Guardian worked with and influenced the Local Authority position in the final care plan is not fully clear from the Cafcass records but may have informed the thinking and judgement regarding the Local Authority position changing from recommending Care Orders for all the children to recommending Sara and her sibling remain in the care of their mother.'* (Cafcass learning review.) Discussion with children's social workers for this review suggests that a combination of the guardian's views and a parenting assessment of Birthmother changed the care plan from

[33] https://www.communitycare.co.uk/social-workers-question-decision-making-of-family-courts-3/

[34] https://basw.co.uk/about-social-work/psw-magazine/articles/respect-social-workers-court-most-senior-family-judge-tells

adoption to recommending Sara and her sibling remain in the care of their Birthmother. Since this time, Cafcass and local authorities (via the ADCS) have acknowledged the need to have a mechanism for fundamentally different views to be explored. Guidance is now in place which recommends that where there is a fundamental difference of opinion a pre-final hearing meeting can take place where possible before final evidence is filed. A template has now been developed [35] to be used setting out the key points of difference to the judge.

The role of supervision orders

5.50 Both sets of public law hearings resulted in the children being subject to a supervision order and work within Surrey took place within a national context of varying practice across local authorities with the usefulness of standalone supervision orders being questioned[36]. The Public Law Working Group in 2021 noted ongoing concerns about supervision orders and recommended the creation of a sub-group to consider the issue further[37]. It also recommended that the government should review supervision orders with the aim of providing '*a more robust and effective form of a public law order'*. The final Public Law Working Group report in 2023[38] highlights significant core principles that are in place and are important to adhere to when implementing supervision orders. These are highly relevant in this case:

- *'Partnership and co-production with children and families.*
- *Multi-agency, multi-disciplinary working.*
- *Clear, tailored plans including to address ongoing risks, and the findings and conclusions of the court in care proceedings.*
- *Resource clarity.*
- *Formal, robust review.*
- *Accountability.*

5.51 If adhered to, these principles will undoubtedly improve the way in which supervision orders operate. The issue of the need for *clear, tailored plans including to address ongoing risks, and the findings and conclusions of the court in care proceedings*, would have been particularly important for Sara and her siblings.

5.52 For a supervision order to be made the court must have been satisfied that the grounds for a care or supervision order contained in section 31 Children Act 1989 exist[39]. However, despite the threshold for significant harm being met, currently there is no legislative requirement for a support plan to be agreed at the time a supervision order is made. Additionally, the wording of the legislation that the order requires the local authority to "advise, assist and befriend" does not always reflect the complexity of the child's situation including managing risk of harm. As a result, the way in which plans are developed varies across local authorities with some automatically progressing in the initial stages to a child protection plan whilst others support the family under a child in need plan.

5.53 For Sara, the child in need plans developed alongside the supervision orders did not utilise the wealth of information gathered during the court hearings and there was an overreliance on what Birthmother needed to do to provide safe care. The family support worker provided a high level of support but

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[35] Guidance-for-when-Guardian-and-LA-views-fundamentally-differ-FINAL.pdf

[36] Harwin, J., Alrouh, B., Golding, L., McQuarrie, T., Broadhurst, K., and Cusworth, L. (2019). The contribution of supervision orders and special guardianship to children's lives and family justice. Summary report. Available from: https://www.cfj-lancaster.org.uk/projects/supervision-orders-and-special-guardianship-a-national-study

[37] Public Law Working Group. (2021). Recommendations to achieve best practice in the child protection and family justice systems. Final report. Available from: https://www.judiciary.uk/wp-content/uploads/2021/03/March-2021-report-final_clickable.pdf/

[38] Public Law Working Group -April 2023 Report (Supervision Orders) - April 2023 Report (Supervision Orders) - Final df

[39] The s31 criteria are: 'the child concerned is suffering, or is likely to suffer, significant harm; and that the harm, or likelihood of harm, is attributable to (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give him; or (ii) the child's being beyond parental control

there was little focus on Father's actions. The plan following the second set of proceedings did include ensuring contact with Father was supervised but when at the end of the order he still had not completed the domestic violence perpetrator course and there were no plans for how contact would be managed in the future. It seems that the original concerns during the care proceedings were not taken into account in the decision to stop the involvement of children's social care.

Professional understanding and management of child contact, domestic abuse and parenting

5.54 Through all three sets of family justice proceedings, the issue of child contact in the context of domestic abuse and the impact on parenting was crucially important.

5.55 These issues were considered In June 2022, when Women's Aid published a report[40] urging action to be taken in the Family Court following the 'Harm Panel' report from 2020 and provide a context for the development of learning from this review by the Surrey Safeguarding Children Partnership and the Local Family Justice Board. This report notes that '*Renewed attention should be placed onto the Harm Panel's recommendations for multi-disciplinary training for all participants in the family justice system, which should include a significant cultural change element, to tackle biases, myths and stereotypes around domestic abuse, child contact and parenting. Currently, different groups of professionals working in the Family Courts receive different training. The Harm Panel identified a significant weakness in the knowledge and skills of Social Workers who are undertaking risk assessments and other related direct work with children and their families where domestic abuse is alleged, suspected or known.'*

5.56 Cafcass have responded well showing great self-reflection to the 'Harm Panel" report with a comprehensive update of their domestic abuse guidance alongside a trained domestic abuse champion in every team, a suite of practice aids and an audit process to monitor how well the new policy is being assimilated. These improvements sit alongside domestic abuse specialists being located in the local Family Justice Board.

5.57 The issue of knowledge and skills in working with domestic abuse was explored in the previous section of this report.

Safeguarding children within private law proceedings

5.58 Private law proceedings differ from public law in that they deal with disputes between individuals over a child's upbringing and welfare, including agreeing where a child should live and what the contact arrangements should be with each parent or guardian. Local authority children's services only become involved when concerns about the child's safety or welfare are raised during the proceedings. The third set of court proceedings involving Sara were private law proceedings and came about because Father applied to the court for a Child Arrangements Order[41], and the purpose of the proceedings was to determine where Sara should live and what the contact arrangements should be. Father and Stepmother's application stated that Sara and her sibling had been living with them since March 2019, after Sara had made allegations of physical abuse against Birthmother. The same judge who heard the previous care proceedings presided over these private law proceedings.

5.59 The procedures governing private law hearings required a Cafcass family court advisor to provide a safeguarding letter to the judge. The detail of this process is set out earlier in this report. The safeguarding letter was completed in July 2019 and set out details of the family history, including the previous concerns about Father as a perpetrator of domestic abuse and recommended that the local authority should be required to complete a section 7 report given their extensive involvement with the family and knowledge of the children.

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[40] Women's Aid. (2022) Two years, too long: Mapping action on the harm panel's findings. Bristol: Women's Aid

[41] A Child Arrangements Order is made under Section 8 Children Act 1989 and sets out arrangements for where the child lives, who they spend time with and how often.

5.60 At this point the Cafcass family court advisor could have made a safeguarding referral to the local authority and/or ask the judge to order Surrey County Council to complete a Section 37 investigation[42]. This was not done. This review believes that there was sufficient evidence that Sara and her sibling were at risk of significant harm to instigate procedures that focused on this potential risk. Sara and her sibling were living with the parent with whom they had previously only been having supervised family time with. This had been stipulated in a signed written agreement at the conclusion of the care proceedings and was to remain supervised during the one-year supervision order. Although the supervision order had ended, his violent history was known by the Police and Surrey Children's Services as well as Cafcass in the earlier two sets of public law proceedings. None of the risks that Father posed had been dealt with, namely the domestic abuse, and there was no mention of the mental health issues that only a couple of years prior had been experienced by Stepmother.

5.61 The problem arising from the completion of a Section 7 report rather than a Section 37 report was that section 7 reports are generally undertaken in circumstances where children are living in less complex circumstances than Sara. The assessment was allocated to an inexperienced social worker who did work hard to engage with the children and hear their views. However, children's voices and the self-reported information from adults in the family was not triangulated with other information (such as domestic violence perpetrator report) and set within the context of what had been previously known. Sara's half-sibling's experience was entirely absent from any consideration of how contact arrangements with birthmother might work.

5.62 It is unclear how well other professionals understand what is needed when assessments are being undertaken within the family justice system. For example, information from the GP did not include any information about Father or Stepmother, including Stepmother's mental health. This review has identified the need for clarity of process in the way that information is requested with clear explanations of what is required and why. Expected standards regarding information sharing also need to be clear, particularly in the way that health information is shared. For example, it is not acceptable for personal medical summaries to be shared of all health consultations with no interpretation and an expectation that social workers should analyse complex health information.

5.63 When reading the final Section 7 report, the manager did recognise gaps in the analysis but did not believe that the case met the threshold for public law, particularly as father had unsupervised contact with the children for the previous three years. Whilst this was the professional judgement of the manager at the time, it is the view of the lead reviewers that there is sufficient evidence that an alternative decision should have been made. These are important reports with fine judgements being made affecting children's wellbeing, yet there is no oversight of the final report apart from the team manager's sign off. Unlike in public law cases there is no routine scrutiny from local authority legal teams which provide a needed additional layer of objectivity and challenge.

5.64 Ultimately the final report which was filed in court did not cover important information. This was not known to the judge who praised the quality of the report.

5.65 The transcript of the hearing seems to set out problems that can occur due to the focus of a private law hearing on resolving a dispute between adults rather than having a broader focus on the safety of children. There is also a lack of information transfer between proceedings which was not overcome by the fact that the same judge presided over both. The information set out earlier in this report shows evidence this hearing focused on contact arrangements for Birthmother to see Sara. Any information from previous public law proceedings about Father's domestic abuse, past violence to the children, and the previous requirement that he completed a domestic abuse perpetrators programme before having unsupervised contact did not, as it should have done, influence these proceedings. The section 7 report contained no consideration of Stepmother and her mental health or how they would

[42] Section 37 of the Children Act 1989 empowers the court to direct local authorities to conduct investigations into the circumstances of a child. It states 'Where, in any family proceedings in which a question arises with respect to the welfare of any child, it appears to the court that it may be appropriate for a care or supervision order to be made with respect to him, the court may direct the appropriate authority to undertake an investigation of the child's circumstances.

cope in their household of two bedrooms with four children (two more children were born subsequently.) There was confirmation in the court order that Birthmother still retained parental responsibility and was entitled to information about the children from the school and provided by the school.

5.66 It could be argued that Judge accepted the recommendations of Surrey Children's Services as laid out in the Section 7 report without further scrutiny. This is not new or isolated to Surrey. National research has also confirmed that there is a need for safeguarding agencies and courts to reflect on how decisions are made. The findings of an analysis of serious case reviews (Brandon et al 2020) commented. *"An adversarial system, judges make their decisions on the evidence and arguments presented to them, and it may be that weaknesses in local authority practice and/or the way it presents its case explain decisions which subsequently appear to be 'wrong.' Without knowing more about the detail in individual cases we cannot say that a court's decisions were 'right' or 'wrong;' and just because a case ends sadly, it does not necessarily mean it was the wrong decision at the time – unpredictable events happen, things can and do change. But no-one would claim that courts are always right – that is why there is an appeal system, a point made in the SCR on Child N, and judgments are sometimes overturned. However, that may not be the most productive system for inter-agency learning. There could be much to be learned from respectful and reflective discussions between courts, local authorities and other agencies. (2020 Brandon et al.)* [43]

5.67 Another area of learning identified within this review is ensuring that private law hearings have the same status as public law hearings when considering the safety of children. The current processes which focus on disputes between adults in private law hearings do not enable family court advisors to see children when making initial decisions or the consideration of the safety of the children involved. In response to the "Harm Panel report" this position is being reviewed with the Private Law Pathfinder Pilots with a stated aim of improving *the experiences of families in child arrangements proceedings, reduce the re-traumatisation of victim-survivors of domestic abuse, reduce the amount of time families spent in court and to improve coordination between agencies."*[44]. The government has set out their intention to expand the pilot[45] with a child impact report and the provision for independent domestic abuse services to assess risk at the information gathering and assessment phase being integral to the approach. This could have made a substantial difference to the way in which Sara's situation was understood in the private law proceedings.

5) Race, Culture, Religion and Ethnicity

5.68 The Child Safeguarding Practice review panel "It's Silent": Race, racism and safeguarding children Panel Briefing in March 2025[46] highlighted issues that are also relevant learning within this review. *'Firstly, the analysis has evidenced a prevailing and powerful silence in talking about race and racism. It is important to acknowledge that discussions about race and racism can, and will be, confronting and difficult. They are, however, very necessary. Racism is insidious, pervasive and deeply embedded in society. The recognition of racism and racial bias as a societal issue is a crucial step in reflecting on, and learning more about how Black, Asian and Mixed Heritage children are safeguarded, helped and protected. (1.17 Pg 6).*

5.69 This is definitely a feature within Sara and her family's lives. Birthmother (a Polish-national) told the review that she felt that people, including the Pakistani community, looked down on Polish people. Father told the lead reviewers that he felt he was not believed by professionals, and nothing

[43] Brandon M et al (2020) 'Complexity and challenge: a triennial analysis of SCRs 2014-2017. Department for Education.
[44] Barlow C et al (2025), 'Private Law Pathfinder Pilot Process Evaluation and Exploratory Financial Analysis. Ministry of Justice.
[45] https://assets.publishing.service.gov.uk/media/67e277f770323a45fe6a7067/pathfinder-programme-update.pdf
[46] The Child Safeguarding Practice Review Panel (2025) "It's Silent": Race, racism and safeguarding children Panel Briefing.

happened when he complained because he was a Pakistani. Professionals and agencies could disagree with his view, and in fact this review itself has argued that he lied and groomed professionals to believe what he wanted them to. However, it must be accepted that this was his perception in relation to his race and is most probably the perception held much wider within their respective communities. The meaning of the word community in this context is about race and nationality and not the place within which they happened to live. The Child Safeguarding Practice Review Panel briefing commented '*The concept of 'community' can be used in different ways and with different meanings; it can, for example, be used to refer to people connected to a specific locality and geography, or to social groups organised around common characteristics such as religion, ethnicity and sexual identity.' (5.23 Pg 39).'*

5.70 Sara had a complex heritage, born to a Polish mother and Pakistani father. Born and brought up in England in a white English working class neighbourhood and attending predominately white schools. Sara's sights and sounds were English, but her home life was with her parents who were not of English heritage. Later she lived with her Pakistani born father and Stepmother who was of Pakistani heritage. Professionals never explored how this impacted on Sara, or her family. The Child Safeguarding Practice Review Panel's report, supports this view, *'In significant and diverse ways, we observed a lack of understanding about children's lived experiences, including missed opportunities to consider the multiple intersecting identities of children and how this may influence their risk, vulnerability and engagement with services.' (5.46 pg. 46).*

5.71 There is no evidence in the children's services records or health records that race, culture, religion or heritage were considered. This is a feature throughout Sara's life with Birthmother having inconsistent access to Polish interpreters and most notably there was no interpreter or other adjustments to help her navigate the private law proceedings in 2019.

5.72 The Police records contain the hate crime incidents that Father reported had taken place towards him. The example of Sara and her siblings being present in the car when Father was racially abused, a safeguarding referral being submitted to the P-SPA but not assessed as needing to be shared wider indicates the need to ensure that sufficient attention is given to trauma children may have experienced and to share information with relevant agencies. In this incident a hate crime risk assessment was completed and graded as standard but there was no contact with children's services or health agencies. Since this time Surrey Police have invested heavily in raising awareness around hate crime and signposting victims/witnesses to support agencies.

5.73 Any consideration of race and culture needs to sit within a context where the views of families are heard and there are the right culturally appropriate services available to support families. For example, it cannot always be assumed that families will want racially matched services and if this is the case Stepmother informed mental health services that she wanted to be seen by an English person and made disparaging remarks about Asian people saying that Asian culture was 'complex and selfish'. She went on to say that other cultures think about children first but said that her culture worried about the family image. There is no evidence that this was explored further with Stepmother at the time and an attempt made to understand what lay behind her remarks, especially when she also commented that she didn't want a counsellor from her own community as she felt that information would get back to her family. Within this context it is significant that when she went to see a solicitor to discuss leaving Father she sought someone outside the area. There is however an example of a confidential service specifically for ethnic minority women in Surrey experiencing domestic abuse which may have been of help. Sitting within Surrey Minority Ethnic Forum (SMEF) the 'Trust Project' supports women from all ethnic minority communities and highlights the benefit of understanding of the context and community of the victims/survivors' situations. However, it is not consistently well known by practitioners in health and children's services.

5.74 The evidence within this review indicates that although Father was Muslim, he was not known to the local mosque or known by professionals to be an active follower of his faith. His insistence that Birthmother changed her religion to the Islamic faith was most likely part of a pattern of coercive control and she reverted to her catholic faith when their relationship finished. No one seemed to

explore with Father, Birthmother, Stepmother or children the importance of religion to their family and assumptions seem to have been made which conflated race, culture and religion.

5.75 It was within this context that the decision of Sara to start wearing the hijab in 2021 took place. She was eight years old. The school showed appropriate curiosity by talking to Sara and Stepmother and accepted the explanation that this was linked to Sara's interest with Pakistani culture following a visit to her paternal grandparents in Pakistan. Expert advice given to the review by the local Muslim community suggests that it would have been highly unusual for such a young child to decide to wear the hijab without either members of their family or peers doing the same. The need for easy access to such advice for all practitioners who may lack knowledge about the impact of race/culture/religion on children is an area for further discussion within Surrey and is explored further in finding six. We now know that the wearing of the hijab did, in the later period of Sara's life, hide bruising and injuries to her face and head.

5.76 The neighbours of the family spoke to both the criminal investigation and the review, saying that they were worried about reporting concerns about what they heard within the family's home. They feared being branded as being racist, especially on social media. While understanding their point of view, this is concerning that race was a bar to reporting possible child abuse and it needs to be overcome. The Child Safeguarding Practice review panel report notes that [47] *'DiAngelo (2018) suggests that it is 'white fragility' – or a defensiveness – that is triggered when white individuals, even those who consider themselves to be progressive, encounter racial stress. This can result in individuals turning away from honest dialogue about racism, focusing instead on their own feelings of victimisation rather than on the person or people of colour who have been interpersonally and/or systemically harmed.' 4.21 pg. 21).*

5.77 Another aspect of the review is the identification by the school and neighbours of Sara as a young carer for her siblings, taking on a significant amount of day-to-day care. There is no explicit evidence that this was accepted as more likely for a child within an Asian household, but it is important to make clear that expert evidence to the review is that it would be wrong to assume that it was cultural for an older female child to take on this carer's role for the younger children. Although Stepmother was informed by the school that Sara had been included in their young carers programme Father, when he spoke to the lead reviewers, stated that no one, including the school, informed him that they regarded her as such and he most certainly didn't.

5.78 The impact on children of race, culture and religion intersects with other aspects of their lives. The context for Sara from the time she moved in with Father and Stepmother was living in unacceptable overcrowded accommodation. This was never given the attention it required from the private law hearing onwards. Towards the end of Sara's life there were six children, plus Father, Stepmother and Uncle living firstly in a two-bedroom flat and then latterly in a small three-bedroom house. Sara's school worked hard to remedy this, but it should also have informed the analysis of other professionals working with the family.

5.79 The national child safeguarding panel briefing sets out a clear direction for safeguarding partnerships which chimes with the learning from this review.[48]. *'Understanding race, ethnicity and culture in safeguarding practice is essential for understanding diverse experiences, addressing disproportionality, mitigating bias and stereotypes, building trust and promoting empowerment and inclusion. Intersectional approaches taken by practitioners are short in evidence, despite our analysis showing clear potential for these to be considered.' (5.4 pg. 32).*

[47] The Child Safeguarding Practice Review Panel (2025) "It's Silent": Race, racism and safeguarding children Panel Briefing.
[48] The Child Safeguarding Practice Review Panel (2025) "It's Silent": Race, racism and safeguarding children Panel Briefing.

5.80 Surrey Safeguarding Children Partnership's response to another local review has acknowledged the work that needs to be done to ensure that the needs of black and Asian children are met across the county.

6) Seeking, analysing and sharing of information

5.81 The evidence from this review is that once care proceedings had concluded, the seeking and sharing of information between agencies was inconsistent resulting in lost opportunities to understand Sara's life and, the care she was receiving from Father and Stepmother and the risk that she could suffer significant harm. The reasons for this vary.

5.82 There were significant gaps in information within the section 7 report for the private law proceedings in 2019. Reasons for this included:

- A reliance on self-reported information, including an overreliance on the voice of the child without consideration of factors that may have influenced this.
- The GP omitting to share any information about Stepmother's mental health history. The GP did not find the template sent by the social worker helpful and did not realise that this information was required, although the template did ask for information relating to parenting capacity. One party therefore thought they had requested information, but the request was not understood by the recipient. The partnership needs to consider how best they seek information from health colleagues, in particular GP Practices.
- Lack of interrogation of previous social work records. The review has been told that these are not always easy to navigate (for example the court bundles from care proceedings run to over 1000 pages), and the lack of accurate closing summaries which did not highlight succinctly the previous safeguarding concerns and previous care proceedings. This means that crucial information about potentially reoccurring risks becomes lost. As well as the need to embed good practice regarding closing summaries, the panel for this review have also queried whether investment in digital and AI solutions may assist with information assessment to prevent risk.

5.83 The Multi-agency Partnership enquiry (MAPE) in March 2023 has been explored in detail above but is another example of the importance of seeking information from a variety of sources. This must be based on a good understanding of the dynamics of child abuse. The current overreliance on direct allegations by a child rather than looking at previous concerns is not based on our knowledge (built up over decades) of how hard it is for children to talk about abuse they have suffered.

5.84 The discussions with practitioners have identified that there remain pockets of practice where there are worries about sharing information due to concerns about GDPR. This includes schools talking to other schools if there are concerns about a sibling. Information was also not shared with Home-Start when they contacted Surrey Children's Services. Although they did not specifically ask for information about family history it would not have been unreasonable for this to have been shared, and they were omitted from any information gathering at a later stage.

5.85 National information sharing guidance is clear[49] that GDPR is *not* a barrier to sharing information when there are concerns about the safety of a child. It is important that we do not fall into the trap of establishing a professional hierarchy where information is not shared with, and sought from, those who may know the child and family best. This may include other family members and people within the community.

5.86 Sara's paternal Uncle is one person that has been hardly mentioned in this review. There doesn't seem to be anything known about him by any agency and the criminal investigation and criminal trial were equally unable to establish very much about him. Information should have been sought about him when the MAPE enquiry took place.

[49] https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

5.87 Sara's situation was not one where information has only come together with the benefit of hindsight. A great deal of information, especially about the risks posed by father was available and members of the review panel have commented that "no one joined the dots up". The challenge for this review is to establish how the dots can be joined for other children who need protection.

6 FINDINGS AND RECOMMENDATIONS

6.1 This review of Sara's contact with the safeguarding system contributes to an understanding of her lived experience within her family and how she came to experience horrific abuse. The review reveals many points at which different action could, and we suggest, should, have been taken. It is this accumulation of many decisions and actions over time that contributed to a situation where Sara was not protected from abuse and torture at the hands of her Father, Stepmother and Uncle – these are the people we must stress who are ultimately responsible for her death.

6.2 Specific issues within individual agency practice have been commented on throughout the report and distilled into the overarching learning themes in section four above. This section focuses on the key findings for the safeguarding system at both local and national level, linked to specific recommendations aimed at effecting meaningful system change.

6.3 The final findings and recommendations are drawn from a summary analysis linked to the systems framework set out in 5.2 above.

Finding One

In March 2023. the "front door" of Surrey Children's services, where referrals are received, did not identify that Sara was at risk of being abused by her father, stepmother and uncle. Expected robust safeguarding processes were not followed. Information gathering and assessment at this stage did not adequately triangulate information and respond to the presence of bruising alongside inconsistent explanations. Sara's "voice" expressed through her change in demeanour was not heard.

6.4 The review has identified the importance of a well-resourced front door into Surrey Children's Services staffed by qualified and experienced staff. Integral to this are close working relationships and information sharing with partner agencies and effective management and supervision arrangements which ensure that the expectations of senior leaders are known and implemented.

6.5 In March 2023 the "front door" in Surrey (known as C-SPA) was under pressure and at times a focus on managing demand, meeting timescales and therefore lack of effective management oversight of the quality of day-to-day decision making led, in this case, to the risk of the likelihood of significant harm to Sara being missed. The expected response to bruising where there had been no allegation made by the child against an adult was not set out in any documentation and custom and practice within the team at that time was that this would not meet the threshold for police enquiries or a strategy discussion. The initial thinking was driven by knowledge that a court in 2019 had confirmed that Father and Stepmother could care for Sara and there had been no referrals since. The social worker did not routinely ask their manager for a reflective discussion to assist decision making except in exceptional circumstances as they were aware that their manager was also under pressure. Gaps in information gathering were not identified by the manager signing off the social work decision of "no further action" with a pressure to sign off all decisions before the next working day leading to insufficient scrutiny of practice.

6.6 Since March 2023 Surrey Children Services have taken many important steps to improve practice at the "front door", including an increase in staffing, clear guidance being communicated to staff about expected standards of practice and a rolling audit programme including regular dip sampling of work by a service manager. In addition, there is independent scrutiny and challenge by Surrey's quality assurance leads.

6.7 However, Surrey will not be alone in needing to meet the challenge of ensuring that their "front door" services can provide a safe response in the face of increasing, and in a number of places overwhelming, demand. This safe response will mean balancing an approach which works together with families to identify support needs, with respectful uncertainty where the practitioners mind remains open to a range of possibilities. It is vitally important that the safeguarding system mitigates the human tendency to look for information that confirms an initial point of view, and there is the opportunity for reflective judgement, discussion and effective management challenge and oversight. This review has highlighted the importance of this challenge for Sara to include reflection on culturally competent practice, sound knowledge of domestic abuse and full consideration of how a child's "voice" may be expressed beyond verbal language.

6.8 There has been limited evaluation of the way that multi-agency "front doors" (often referred to as MASH (Multi-Agency Safeguarding Hubs) teams) operate, but a study was commissioned following the Child Protection in England report into the deaths of Star Hobson and Arthur Labinjo-Hughes[50]. This has provided a helpful insight into similarities and differences across England as well as some common challenges. The initial findings as to what needs to be in place when a MASH is working well chime with the findings of this review, namely:

- Timely and relevant information sharing between practitioners.
- Multi-agency informed decision-making by children's social care.
- A reduced likelihood of missing or underestimating risk to a child.
- Swift needs assessment.
- Enhanced practitioner confidence and wellbeing.

6.9 The study also identifies the following implications for policy and calls for further research. These points are endorsed by the findings of this review.

- Safeguarding partnerships should consider whether a MASH could support them to achieve the expectations set out in the Families First Partnership programme guide[51].
- Guiding principles for multi-agency front door services to children's social care could be usefully developed and provided to the sector.
- Specific guidance and resources on parental consent for information sharing in multi-agency safeguarding contexts would be useful to the sector.

Recommendation One

Safeguarding Partners should ensure that robust multi-agency safeguarding processes are in place, understood, adhered to by all agencies and quality assurance processes ensure that they are adhered to. These processes must include the requirement to hold a strategy discussion when a child comes to the attention of professionals with bruising which is suggestive of physical abuse.

Recommendation Two

(i) The Department for Education should build on the 2025 evaluation of MASH and provide clear practice guidance to ensure that "front doors" into children's social care routinely include an evaluation of whether a child is at risk of abuse. Safeguarding processes must be in place at the "front door" to ensure that any bruising to a child is properly assessed and strategy meetings held where there is significant harm or the likelihood of significant harm to a child.

(ii) The National Child Safeguarding Review Panel should be asked to promote good practice at the "front door" of children's services. This should highlight what a good "front door" looks like including (but not restricted to) resourcing and capacity, qualifications and experience of staff, (including specialist domestic abuse practitioners), management and supervision and practice audit. In order to develop this good practice guidance as well as making use of the learning from the 2025 MASH

[50] Child Protection in England - May 2022

[51] The Families First Partnership programme is part of the government's plan for change. This promotes partnership work across social work, police, health and education to make sure that children and families receive the right help at the right time, with an emphasis on the importance of early help. The_families_first_partnership_programme_guide.pdf

evaluation, consideration should be taken from the findings of 'The MASH guiding principles document.' Published in April 2025 by the National Police Chiefs Councils, Vulnerability, Knowledge and Practice Programme.

Finding Two

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 Birthmother 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 within Surrey of offering home visits within 10 days was not followed.

6.10 When Sara was murdered, she was registered as being educated at home and this was a crucial period when she was experiencing horrific abuse out of the sight of professionals. We now know through the information presented at the criminal trial and also shared with the review authors that there would have been unbelievable severe physical injuries inflicted upon Sara during this time period and that it was highly likely that Sara was physically restrained in the house, the 'Ring Doorbell' footage shows that Sara did not leave the house after the 19th July 2023. Sara was also found to be grossly underweight and her bone pathology found her to be severely malnourished which would have happened during and before this period.

6.11 Legislation and statutory guidance did not require parents to notify the school of their intention to home educate and there was no requirement for the local authority to visit at home as long as they were satisfied that the child was receiving a suitable education. The school was required to notify the local authority (in Surrey the inclusion team) if they were aware that a child had been removed from school to be educated at home, which they did. The ensuing discussions between the inclusion team as to whether written notification from Father needed to be supplied and when Sara should be removed from roll contributed to delay in moving onto the next step. In Surrey this is to offer a home visit within ten working days of notification, a process which goes beyond statutory requirements. The offer of a home visit was also delayed due to staff sickness and the change of family address was not noticed by the inclusion team resulting in the practitioners going to the wrong address in the days before Sara's murder. Management systems and oversight did not identify the delay or the issue with the address. Although Surrey has been focused on providing the best possible oversight for home educated children, the policies that were in place were not followed in this case.

6.12 Forthcoming legislation will strengthen oversight of children educated at home, but this would not have helped Sara. The need for parents to obtain consent from the local authority to home educate if a child is subject of section 47 enquiries or on a child protection plan would have excluded Sara who was no longer open to children's social care. The National Child Safeguarding Review Panel's 2024 briefing on elective home education [52] identified that of the 41 children who had been seriously harmed, 25 had been *previously* known to children's social care or early help services. It would not be unreasonable where there has been previous involvement for a multi-agency discussion to take place when an intention to home educate is notified. This would enable an open discussion with parents regarding any extra support that might be needed and enable consideration of any potential risks to the wellbeing of the child. This discussion could also be required when one parent objects to a child being educated at home.

6.13 Guidance is currently unclear regarding elective home education and separated parents, one of whom may object. At the very least all parents with parental responsibility should be informed and there needs to be a clear pathway to follow if one parent objects. The current Department for Education guidance as to the role of the school and the local authority at this point is ambiguous, and although the school did give birthmother's details to the inclusion team she was not contacted and

[52] CSPRP_Elective_Home_Education_Oct_2024.pdf

therefore any potential objections were not heard. If she had been heard, within current guidance we cannot feel confident that her voice would have held any weight. A formal process (linked to the multi-agency discussion above) would have been another opportunity for agencies to think about what life was like for Sara and why her Birthmother was worried.

6.14 Surrey County Council is working to strengthen and develop policy and practice relating to elective home education including clarifying the checks and enquiries that inclusion officers will make when they receive an elective home education notification. A request for support will be made to children's social care where there are concerns about a child and the triage process needs to ensure that police checks are then routinely carried out.

Recommendation Three

The Department for Education should:

- Review contradictions between pupil registration requirements and legislation and guidance underpinning Elective Home Education.
- Update statutory guidance to:
  - Require a formal meeting with parents and professionals to assess support needs in all cases where a child has been previously known to children's social care, is currently known to children's social care or the school has recorded concerns about the wellbeing of the child before receiving notification.
  - Ensure that all parents with parental responsibility are consulted when a decision has been made to educate a child at home and there is a clear pathway to follow if one parent objects.
  - Include a requirement that a home visit should always take place and children seen within two weeks of notification of withdrawal from school to home educate.
- Work with the National Child Safeguarding Review Panel to consider the findings of the review in relation to Elective Home Education.

Recommendation Four

Surrey County Council should work with Surrey Police to incorporate police checks into the process for responding to elective home education notifications. This should include ensuring that the elective home education service always shares such notifications with the C-SPA for prompt triage to identify any child open to Surrey children's social care or for whom a previous safeguarding concern has been raised, and that via the C-SPA police checks are carried out for children found to be in either of these categories.

Finding Three

Work with Father as a domestic abuse perpetrator was not integrated to childcare assessment and plans. The seriousness and serial nature of Father's abusive behaviour to his family was not recognised beyond the second set of care proceedings. There was an assumption that attendance at a group programme for domestic abuse perpetrators was sufficient and Father's account of completion of this programme was all that was needed. There was no clear statement of what needed to change to mitigate his future risk to women and children and how change in his behaviour would be evaluated.

6.15 The information set out within this review identifies Father as a dangerous serial abuser of women and children. Although domestic abuse was recognised as a risk factor during the two sets of public law proceedings, following these proceedings recognition of the serious nature of Father's violence and the impact on children became diluted. The plan accompanying the second Supervision Order included an agreement that he should complete a domestic abuse perpetrator programme. Too much credence was given to Father's assurances that he had completed a treatment programme and this reliance on self-report shows a lack of understanding of domestic abuse at that time. This lack of understanding of domestic abuse was also evident in responses to Birthmother whose behaviour and responses were not understood through the lens of a domestic abuse survivor. As time went on, and especially during and after the private law proceedings, she became marginalised, and we believe wrongly negative views of her became entrenched in professional responses.

6.16 There was no known disclosure by Stepmother to any professional, but we now know that she did seek advice and support from her sister and a lawyer. It is possible that assumptions were made about the potential for the abuse of Stepmother to be less because they were a cultural match. Within the local area there is now a project working with ethnic minority women who are survivors of domestic abuse which brings expertise and knowledge of the cultural factors that might prevent women from leaving an abusive relationship. This service is not consistently well known amongst the professional community and funding is limited but the importance for culturally relevant services, especially where children may be victims of domestic abuse is highlighted by this review. This is further explored in finding six.

6.17 Work with domestic abuse perpetrators and survivors has now developed in Surrey and is an integral part of the Family Safeguarding Model. Domestic abuse specialists work with families where children are subject of child in need or child protection plans. The model of intervention is 1:1 and the feedback loop to children's social workers is now in place. One remaining area for development is where children are subject of a supervision order and work is required with the domestic abuse perpetrator. As the model of intervention requires motivation to change the programme is not available to anyone who is subject of any court order. This is a potential gap which needs to be addressed as this was precisely the issue found within this review.

Recommendation Five

(i) All managers and practitioners involved in safeguarding children need to have a good knowledge of the 'modus operandi' of domestic abuse perpetrators. This includes how they manipulate through coercive and controlling behaviour and groom professionals by their disguised non-compliance. Management and supervision sessions must ensure that a focus is maintained on any current risks to women and children through domestic abuse.

(ii) Multi-agency domestic abuse training should take place both locally and nationally for practitioners and managers. This should include both knowledge of all aspects of domestic abuse, including perpetrator behaviours and beliefs and attitudes underpinning responses. The outcome should be that tackling of domestic abuse is seen holistically and a whole system issue.

(iii) At both a local and national level, services to attempt to change behaviours of domestic abuse perpetrators should be reviewed to ensure there is the right range of programmes available. Where children are involved this needs to ensure that there is always a feedback loop from commissioned services to child safeguarding practitioners who are working with the children and families.

Finding Four

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.

6.18 These proceedings were pivotal. From this point the child arrangements order that was made meant that Sara legally resided with Father and Stepmother. This decision had a powerful influence on professionals who subsequently came into contact with Sara and her father as the assumption was that the assessments carried out at that time had ensured that this was a safe and loving home. As a result, some of the unconscious and conscious red flags that might have alerted professionals (in school and C-SPA) to the abuse of Sara within the home were not recognised. The problem of perceptions of professional hierarchy driving practice has been well documented over several decades[53] and it is evident that court decisions were perceived to be at the pinnacle of the hierarchy in this case.

[53] Reder, P., Duncan, S. and Grey, M. (1993) *Child Abuse Tragedies Revisited.* London: Routledge

6.19 The evidence within the proceedings had significant gaps which have been documented in this report. Significantly the section 7 report was missing vital information and analysis as a result of information within the files not being thoroughly reviewed. Information sharing from the GP omitted important details about Stepmother's mental health history and there was no routine scrutiny of these reports by Surrey legal services. Although there was good direct work with the children this was out of context of previous concerns, there was therefore an over reliance in this instance on the voice of the child. The only point of disagreement was contact arrangements. When asked in court if she agreed that the children should live with Father and Stepmother and she should have supervised contact, Birthmother said yes. The remaining issue discussed in court was whether Stepmother should supervise contact. It is however important to note that Birthmother represented herself in court, there was no interpreter present and there was no obvious understanding of the impact of the power imbalance between Birthmother, the Court and Father /Stepmother, in the context of her experience as a survivor of domestic abuse.

6.20 In November 2019, which was after the conclusion of these proceedings, Cafcass and the Association of Directors of Children's Services published good practice guidance for section 7 reports[54]. This included a template with the aim of developing a consistent approach. The guidance established the importance of practitioners completing reports having "advanced social work expertise" and the need for a safeguarding assessment as part of the process. This guidance understandably highlights the potential for emotional abuse but there would be the opportunity to strengthen consideration of physical harm.

6.21 This case highlights the importance of the Cafcass safeguarding letter being reviewed by the social worker completing the section 7 report. Had this been reviewed, Father's history would have been unlikely to have been missed. Currently not all Cafcass safeguarding letters are received by local authorities and there is an opportunity for section 7 guidance to clarify the role of the court in sharing the safeguarding letter at the same time as a direction for a section 7 report.

Recommendation Six

(i) Practice guidance underpinning Section 7 reports and other reports for private law family justice should be updated to include a requirement that the safeguarding letter filed by Cafcass should also be sent to the organisation completing the section 7 report and always be reviewed as part of the process. Section 7 reports should be subject to the same level of scrutiny within the local authority as documents provided for care proceedings.

(ii) When the local authority and/or Cafcass are involved in private law proceedings they should, if they believe that it may be appropriate for a care or supervision order to be made, request that the court considers whether an order is made for the local authority to complete a section 37 investigation instead of a Section 7 report.

Recommendation Seven

The potential for safeguarding risks not being recognised or addressed in private law proceedings must be eradicated. This should be approached through the work of both Local and National Family Justice Boards to specifically focus on changing culture, policy and procedure that private law is not just about family dispute resolution in relation to the children involved but to recognise the risks in particular during separation to not just the adult but also the children.

Recommendation Eight

Where a parent's first language is not English the appropriate process should always be that an interpreter is available to ensure that there is a full understanding of the complex court proceedings. Where this is not possible due to capacity and there is a risk of delay to the proceedings the court should on all occasions ensure that the parents understand what is happening at each stage of the proceedings.

[54] https://www.adcs.org.uk/wp-content/uploads/2024/04/Section7_Template_Resource_Pack_web.pdf

Finding Five

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 and problems associated with the effectiveness of supervision orders in keeping children safe have been identified as a national issue.

6.22 The events surrounding the two sets of care proceedings have been important to understand and consider during the review as they were an early opportunity to bring Sara into the care of the local authority. The numerous and voluminous documents contained within court bundles highlight the challenges facing all involved when making crucial decisions about children's lives. Within this system it is the legal responsibility of the local authority to present evidence to support their application for an order and the final care plan. The children's guardian has a legal duty to undertake their own independent enquiries and scrutinise the evidence of the local authority.

6.23 On both occasions the local authority's initial application was for a care order, and their final care plan was for Sara to remain living within her family under a supervision order. It became clear during the course of this review that the perception of social workers is that the court will give more weight to the view of the children's guardian. Having taken legal advice and once it became clear that the children's guardian's rationale that they provided to the court would not support the application for a care order, they had, in their view, no option but to change their care plan.

6.24 The need for there to be a mechanism for identifying, recording and informing the court of any points of difference between the children's guardian and the local authority has been recognised with new guidance issued in 2025. This is to be welcomed but there will be work to do in some, but not all, local areas to establish a culture where there is a balance of both perceived and real equity across the parties. A culture and the perception of local authority social workers that their views and their opinions are less valued within the family justice system needs to change.

6.25 Once a supervision order was made, on both occasions there was an insufficiently robust, outcome focused, multi-agency plan. There were regular support visits but (particularly during the second order) Father was able to manipulate professionals and dilute the focus on him as a risk to women and children. Problems with the implementation of supervision orders is an issue beyond Surrey with varying practice and expectations across local authorities. It is arguable that since the threshold for significant harm must be met for the order to be made, children should initially be subject of a child protection plan whilst the right support and monitoring processes are established. At the conclusion of the order, it is also important that a review establishes whether any risks identified during care proceedings have now been mitigated by effective support.

6.26 Ensuring that supervision orders meet the needs of children and protect them from harm is an issue wider than Surrey. Reiteration of the principles underpinning supervision orders by the public law working group is welcomed but further work is now needed to ensure that the implementation of all supervision orders includes consideration of equality and diversity, and plans ensure that all necessary reasonable adjustments are made. Implementation must now be monitored.

Recommendation Nine

When the independent advice of the children's guardian and the assessment of the local authority differ, this should be recorded in line with guidance (July 2025) to enable the lead judge in the case to read in summary form, the points of difference before the judge in respect of the care plan. This will save the court time and will enable parties to consider these points in detail as decisions are made. An audit is recommended for local and national family justice boards to complete in twelve months' time which could help to indicate how successful this guidance has been.

Recommendation Ten
In order to ensure that children subject of supervision orders are adequately protected from significant harm:
(i) The principles set out by the public law working group for the implementation of supervision orders should become expected practice in all local areas and further evaluation carried out to ensure that these adequately protect children from significant harm.
(ii) The principles should be reviewed and include a requirement that the implementation of supervision orders is based on consideration of equality, diversity and inclusion, and advice has been taken from those with relevant knowledge, expertise and lived experience.

Finding Six
The review has found that there was 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 Birthmother was almost non-existent and in private law proceedings this had a negative impact on her ability to be heard and contribute.

6.27 The review has explored the way in which the interacting aspects of Sara's identity and her family's life were never fully named, explored and responded to by practitioners. From an early stage in work with the family there was minimal consideration of the family's dual heritage and an inconsistent use of interpreters for Birthmother which continued, including the private law proceedings in 2019.

6.28 Sara's dual heritage and possible assumptions about her cultural fit within the family of Father and Stepmother were not identified and became particularly relevant when she started wearing the hijab at a young age in a family where this was not the norm. This review has had the benefit of discussions with a respected member of the local Muslim community who was able to identify the type of questions that could have been asked, and this has highlighted the need for all practitioners to have access to the right expertise and is the subject of a recommendation below.

6.29 Alongside this it is notable that concerns about Father's propensity for domestic abuse seemed to lessen once he was with Stepmother instead of there being any thought given as to potential barriers to her disclosure. There is a need for culturally relevant services, and a recommendation has been made about the further development of good practice that is already in place.

6.30 Lack of proper consideration of race and culture within safeguarding practice is not confined to Surrey, and the National Child Safeguarding Review Panel findings referred to earlier within this report provides the national context as well as important reflective questions for Safeguarding Partnerships. A recent multi-agency learning review carried out by Surrey Safeguarding Children Partnership has already resulted in action to promote inclusion and positive engagement with minoritised groups and to include members of minoritised communities in strategy development. This work will provide a foundation for moving forward with the recommendations of this review.

Recommendation Eleven
(i) Surrey Safeguarding Children Partnership should require all agencies to develop a pathway for practitioners to consult with experts where they need additional knowledge about context and practice across diverse family cultures. This should include consultation with local organisations from minoritised communities who are already providing services in the field of domestic abuse and safeguarding.
(ii) Safeguarding audit activity (multi-agency and single agency) should always include a review of the level to which a child's culture and heritage is highlighted and explored within day-to-day practice. This includes the opportunity to reflect on the impact of assumptions and biases on decision making and whether there is a need to improve practitioners' cultural competency.
(iii) Surrey Safeguarding Children Partnership must highlight to all practitioners from early help through to those that work in the family court that a person's ability to communicate conversationally in English does not negate the need for all official meetings to employ the services

of an interpreter. Where this is not possible due to capacity and there is a risk of delay to child protection or child in need processes, professionals should on all occasions ensure that children and their parents understand what is happening at each stage.
(iv) Surrey Safeguarding Children Partnership should benchmark their local strategy policy, procedure and practice against the recommendations and reflective questions set out in the National Child Safeguarding Practice Review Panels report on racism and safeguarding children.

Finding Seven

Work with the family in health, social care and education lacked a consistent whole family approach which gathered all relevant information including past involvement and knowledge of the wider family. This was influenced by staffing capacity alongside a lack of confidence and knowledge about what information could be sought or shared and the roles and responsibilities of other safeguarding professionals.

6.31 Information gathering and sharing is a recurring theme in safeguarding reviews, and this review is no different. What is clear is that this needs to be understood both in terms of in-house gathering of information from past records and sharing across agencies. A wide range of reasons contributed to a failure to "join the dots" and recognise that Sara was at risk of abuse from her Father, Stepmother and Uncle.

6.32 With hindsight it is now clear that Sara had a long history of involvement with statutory agencies and that her father had been implicated in both the abuse of children and women. Any scrutiny of history would identify that there was little objective evidence to support his claim that he was no longer a risk, emphasising the danger of any approach which understands the needs of children only through the lens of current knowledge. Too much emphasis was given to Father's self-reported version of events alongside an overreliance by both Sara's school and Surrey Children's Services on the court judgment in the private family proceedings that granted him a child arrangements order. As has been identified elsewhere in this report, courts are often seen as being at the pinnacle of professional hierarchy and this affected professional judgements in the absence of a detailed analysis of past information.

6.33 Unravelling Sara's history has taken this review many days, time that would not be available to practitioners who are often required to carry out their work within tight timescales. Within Surrey Children's Services there is an acknowledgement that "history is important" and that steps must be taken at the front door to gather and weigh up the significance of past involvement. This must also be backed up by systems that makes information accessible including closing summaries and chronologies of key information.

6.34 Within community health services, health visitors are also constrained by capacity to fully interrogate all known information in relation to all children within the household. Consequently, they have to rely on parental report which we now know was not totally accurate at the new birth visit. Electronic systems do not support this task and there is insufficient flexibility to increase visits to vulnerable families outside of mandated contacts. This is within the context of a national shortage of public health nurses which includes health visitors due to a lack of investment / recruitment / retention and an aging professional workforce who have been retiring. The health visiting website notes that health visitor numbers fell by 40% from 2015-2023, a fact acknowledged by the NHS workforce plan which aims to address this[55]. This will take time and today there is a need for all safeguarding professionals to be mindful of the constraints operating in fellow professionals' settings.

6.35 Understanding information within agencies must also be helped by sharing information across agencies. This is often linked with concerns about what can be shared without parental consent and the findings of the MASH evaluation (2025 Pg64) identifies that knowing when to dispense with parental consent is an issue beyond Surrey. Schools within Surrey have also shared that they are

[55] https://ihv.org.uk/news-and-views/news/health-visiting-in-the-nhs-long-term-workforce-plan-in-brief/

uncertain whether they can talk to the school attended by a sibling of one of their pupils if they have concerns and within C-SPA no information was given to Sara's sibling's school as to why information was being requested. National guidance and senior leaders across Surrey Safeguarding Children Partnership are clear that there should be no barrier to sharing information where there are safeguarding concerns. A significant amount of work has already been undertaken across the partnership to demystify the issue of consent, but this needs to be kept under constant review and there may be more work to do where this does not seem to be clear cut.

6.36 Beyond legal constraints, at the heart of this is a system where there is a common understanding of what information is important, why information is being requested and how to make the request and how to share information in a way that helps the person in receipt of the information. For Sara this review has identified there were gaps in the way that information came together across agency boundaries.

- There has been learning identified about the importance of GP information in respect of adults in the family, the best way to ask for information from GPs and how this should then be shared.
- It is clear that referrers into Surrey Children's Services need to give all the information at their disposal and not make assumptions about what might already be found within Children's Services records
- Other organisations such as Home-Start are totally reliant on what is shared with them by other professionals and there is a need to consider carefully the role they have in supporting families and what information they need to do their job.

6.37 Good multi-agency work needs to move beyond simply passing information between agencies and requires effective professional relationships. Although good multi-agency work is taking place in Surrey this review found that effectiveness could be further supported via multi-agency training which is more than simply sitting on a training course with other agencies. Instead, this should provide a vehicle for understanding each other's roles, responsibilities and developing working relationships. In Surrey, although there is a comprehensive training offer, there is no jointly funded programme that facilitates this approach.

Recommendation Twelve

Any real or perceived barriers to information gathering and sharing must be explored at both a local and national level. This can be achieved by providing clear, role specific, practice guidance developed for staff working at the front door, and all those responsible for safeguarding children. As well as developing and embedding as good practice the provision of closing summaries, the exploration in digital and AI solutions may assist with information assessment to prevent risk.

Recommendation Thirteen

The importance of health professionals, and in particular the health visitor role or allied health professionals[56], in safeguarding children should be strengthened. This can be achieved in health visiting by ensuring that the commissioning arrangements within local authorities for health visitor teams are sufficiently funded to enable capacity and flexibility to use evidence-based interventions to respond to complex family circumstances.

Recommendation Fourteen

Surrey Safeguarding Children Partnership should work with partner agencies to review learning and development opportunities including the multi-agency training offer. This should ensure there is opportunity for increased understanding of roles and responsibilities as well as developing effective multi-agency relationships embedded within the learning and development opportunities and that

[56] The Allied Health Professions (AHPs) are the third largest clinical workforce in the health and care sector. There are currently 14 registerable titles for AHPs including physiotherapists, paramedics, dieticians, occupational therapists and speech and language therapists who work alongside other healthcare professionals to support health and wellbeing throughout the life course from birth to palliative care.

individual organisations support their staff to attend and participate so that there are no barriers to specific professional groups attending.

Finding Eight

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.

6.38 Good safeguarding practice depends on knowledgeable skilled practitioners and on those practitioners being supported by systems and processes that enable them to do their job. Alongside this, statutory guidance is clear that local safeguarding partners need to ensure that practitioners are supported to achieve expected standards through:[57]

- an unrelenting focus on protection and the best outcomes for children.
- creating learning cultures in which practitioners stay up to date as new evidence of best practice emerges.
- creating an environment in which it is safe to challenge, including assumptions that relate to ethnicity, sex, disability, and sexuality.
- supporting practitioners with effective supervision, as determined by their regulatory body, in which they can critically reflect on their findings and strengthen their analysis.
- helping practitioners to understand the impact of their decisions on the child.

6.39 Although there were quality assurance systems in place and the Joint Targeted Area Inspection in March 2023 identified strengths in the integrated front door, the inspection noted that safeguarding partners' good understanding of thresholds was incomplete and that there was more to do to ensure this was consistent across the partnership. The inspection also flagged that there were gaps in the decision-making around which information should be sought from health partners. These areas for improvement, are borne out by Sara's experience. Partnership work to develop these improvements was initiated following the inspection and went on to incorporate early learning from the rapid review following Sara's murder, with changes implemented from October 2023.

6.40 In three key areas quality assurance systems did not identify and manage gaps in the practice standards expected within the local authority.

1. The delay in responding to the notification of elective home education.
2. The significant omissions in the multi-agency partnership enquiries after the March 2023 referral from the school.
3. The section 7 report filed in court with gaps in information gathering and analysis.

6.41 On each occasion there were other factors at play including staff sickness, workload pressures and practitioner knowledge and experience. These factors were significant and needed a compassionate and sensitive response. However, this cannot be as an alternative to a system which both supports practitioners to be the best that they can be alongside structured audits and quality assurance activity that maintains a focus on the outcomes for children and their families.

Recommendation Fifteen

Surrey County Council should review and strengthen the existing culture, systems and processes designed to support good practice in working with children and families. This should ensure that:

- Practice standards and expectations are clear and understood.
- Quality Assurance activity within each service identifies where practice is not meeting expectations. This activity should include relevant specialist services.
- Staff development and training expectations are clearly set out and professional development is prioritised at all levels.

[57] Working Together to Safeguard Children (2023) Page 81

- Supervision provides an opportunity to reflect on any barriers to achieving and maintaining good practice, assists practitioners in thinking clearly in complex cases and identifies learning and support needs.

7 CONCLUSION

7.1 Sara's murder understandably caused shock, horror and outrage. There were demands that her legacy must be that there should "never again" be such a tragedy and the weaknesses in our child protection system must be corrected. Throughout this review we have been acutely aware of the responsibility to identify those weaknesses, learn from them and to make recommendations which can support change.

7.2 Whilst there are many points of learning for our child protection system, we are also clear that Sara was murdered by adults who should have loved and cared for her, and they are ultimately responsible for her death. Safeguarding children can never be an exact science. Human decision making is affected by many factors, not all of which are within the control of those organisations charged with keeping children safe. It would therefore be wrong to pretend that system change is easy or will protect every child from adults determined to do them harm. However, what this review does clearly demonstrate is the challenge that practitioners face in establishing a holistic understanding of what is happening for a child and the level of risk where a lot of information, including historical information, is held in individual agencies and individual systems.

7.3 What has become clear during this review is that although the aim will always be to try and work alongside families and support them to care for their children, we must also maintain the capacity to "think the unthinkable". This means that we must remain alert to the possibility that some parents will deliberately harm their children and incorporate consideration of the potential risk of harm into our day-to-day practice. This is not the responsibility of any one agency, and the findings of this review have shown that this applied to work with Sara by different agencies at many points of her life.

8 LIST OF RECOMMENDATIONS

Recommendation One (Local)
Safeguarding Partners should ensure that robust multi-agency safeguarding processes are in place, understood, adhered to by all agencies and quality assurance processes ensure that they are adhered to. These processes must include the requirement to hold a strategy discussion when a child comes to the attention of professionals with bruising which is suggestive of physical abuse.

Recommendation Two (National)
(i) The Department for Education should build on the 2025 evaluation of MASH and provide clear practice guidance to ensure that "front doors" into children's social care routinely include an evaluation of whether a child is at risk of abuse. Safeguarding processes must be in place at the "front door" to ensure that any bruising to a child is properly assessed and strategy meetings held where there is significant harm or the likelihood of significant harm to a child.

(ii) The National Child Safeguarding Review Panel should be asked to promote good practice at the "front door" of children's services. This should highlight what a good "front door" looks like including (but not restricted to) resourcing and capacity, qualifications and experience of staff, (including specialist domestic abuse practitioners), management and supervision and practice audit. In order to develop this good practice guidance as well as making use of the learning from the 2025 MASH evaluation,

consideration should be taken from the findings of 'The MASH guiding principles document.' Published in April 2025 by the National Police Chiefs Councils, Vulnerability, Knowledge and Practice Programme.

Recommendation Three (National)
The Department for Education should:

- Review contradictions between pupil registration requirements and legislation and guidance underpinning Elective Home Education.
- Update statutory guidance to:
  - Require a formal meeting with parents and professionals to assess support needs in all cases where a child has been previously known to children's social care, is currently known to children's social care or the school has recorded concerns about the wellbeing of the child before receiving notification.
  - Ensure that all parents with parental responsibility are consulted when a decision has been made to educate a child at home and there is a clear pathway to follow if one parent objects.
  - Include a requirement that a home visit should always take place and children seen within two weeks of notification of withdrawal from school to home educate.
- Work with the National Child Safeguarding Review Panel to consider the findings of the review in relation to Elective Home Education.

Recommendation Four (Local)
Surrey County Council should work with Surrey Police to incorporate police checks into the process for responding to elective home education notifications. This should include ensuring that the elective home education service always shares such notifications with the C-SPA for prompt triage to identify any child open to children's social care or for whom a previous safeguarding concern has been raised, and that via the C-SPA police checks are carried out for children found to be in either of these categories.

Recommendation Five (National and Local)
(i) All managers and practitioners involved in safeguarding children need to have a good knowledge of the 'modus operandi' of domestic abuse perpetrators. This includes how they manipulate through coercive and controlling behaviour and groom professionals by their disguised non-compliance. Management and supervision sessions must ensure that a focus is maintained on any current risks to women and children through domestic abuse.

(ii) Multi-agency domestic abuse training should take place both locally and nationally for practitioners and managers. This should include both knowledge of all aspects of domestic abuse, including perpetrator behaviours and beliefs and attitudes underpinning responses. The outcome should be that tackling of domestic abuse is seen holistically and a whole system issue.

(iii) At both a local and national level, services to attempt to change behaviours of domestic abuse perpetrators should be reviewed to ensure there is the right range of programmes available. Where children are involved, this needs to ensure that there is always a feedback loop from commissioned services to child safeguarding practitioners who are working with the children and families.

Recommendation Six (National)
(i) Practice guidance underpinning Section 7 reports and other reports for private law family justice should be updated to include a requirement that the safeguarding letter filed by Cafcass should also be sent to the organisation completing the section 7 report and always be reviewed as part of the process. Section 7 reports should be subject to the same level of scrutiny within the local authority as documents provided for care proceedings.

(ii) When the local authority and/or Cafcass are involved in private law proceedings should, if they believe that it may be appropriate for a care or supervision order to be made, request that the court considers whether an order is made for the local authority to complete a section 37 investigation instead of a Section 7 report.

Recommendation Seven (National and Local)
The potential for safeguarding risks not being recognised or addressed in private law proceedings must be eradicated. This should be approached through the work of both Local and National Family Justice Boards to specifically focus on changing culture, policy and procedure that private law is not just about family dispute resolution in relation to the children involved but to recognise the risks in particular during separation to not just the adult but also the children.

Recommendation Eight (National)
Where a parent's first language is not English the appropriate process should always be that an interpreter is available to ensure that there is a full understanding of the complex court proceedings. Where this is not possible due to capacity and there is a risk of delay to the proceedings the court should on all occasions ensure that the parents understand what is happening at each stage of the proceedings.

Recommendation Nine (National)
When the independent advice of the children's guardian and the assessment of the local authority differ, this should be recorded in line with guidance (July 2025) to enable the lead judge in the case to read in summary form, the points of difference before the judge in respect of the care plan. This will save the court time and will enable parties to consider these points in detail as decisions are made. An audit is recommended for local and national family justice boards to complete in twelve months' time which could indicate how successful this guidance has been.

Recommendation Ten (National)
In order to ensure that children subject of supervision orders are adequately protected from significant harm:
(i) The principles set out by the public law working group for the implementation of supervision orders should become expected practice in all local areas and further evaluation carried out to ensure that these adequately protect children from significant harm.
(ii) The principles should be reviewed and include a requirement that the implementation of supervision orders is based on consideration of equality, diversity and inclusion, and advice has been taken from those with relevant knowledge, expertise and lived experience.

Recommendation Eleven (Local)
(i) Surrey Safeguarding Children Partnership should require all agencies to develop a pathway for practitioners to consult with experts where they need additional knowledge about context and practice across diverse family cultures. This should include consultation with local organisations from minoritised communities who are already providing services in the field of domestic abuse and safeguarding.
(ii) Safeguarding audit activity (multi-agency and single agency) should always include a review of the level to which a child's culture and heritage is highlighted and explored within day-to-day practice. This includes the opportunity to reflect on the impact of assumptions and biases on decision making and whether there is a need to improve practitioners' cultural competency.
(iii) Surrey Safeguarding Children Partnership must highlight to all practitioners from early help through to those that work in the family court that a person's ability to communicate conversationally in English does not negate the need for all official meetings to employ the services of an interpreter. Where this is not possible due to capacity and there is a risk of delay to child protection or child in need processes, professionals should on all occasions ensure that children and their parents understand what is happening at each stage.
(iv) Surrey Safeguarding Children Partnership should benchmark their local strategy policy, procedure and practice against the recommendations and reflective questions set out in the National Child Safeguarding Practice Review Panels report on racism and safeguarding children.

Recommendation Twelve (Local and national)
Any real or perceived barriers to information gathering and sharing must be explored at both a local and national level this can be achieved by providing clear role specific practice guidance developed for staff working at the front door, and all those responsible for safeguarding children. As well as developing and

embedding as good practice the provision of closing summaries, the exploration in digital and AI solutions may assist with information assessment to prevent risk.

Recommendation Thirteen (Local)
The importance of health professionals, and in particular the health visitor role or allied health professionals, in safeguarding children should be strengthened. This can be achieved in health visiting by ensuring that the commissioning arrangements within local authorities for health visitor teams are sufficiently funded to enable capacity and flexibility to use evidence-based interventions to respond to complex family circumstances.

Recommendation Fourteen (Local)
Surrey Safeguarding Children Partnership should work with partner agencies to review learning and development opportunities including the multi-agency training offer. This should ensure there is opportunity for increased understanding of roles and responsibilities as well as developing effective multi-agency relationships embedded within the learning and development opportunities and that individual organisations support their staff to attend and participate so that there are no barriers to specific professional groups attending.

Recommendation Fifteen (Local)
Surrey County Council should review and strengthen the existing culture, systems and processes designed to support good practice in working with children and families. This should ensure that:

- Practice standards and expectations are clear and understood.
- Quality Assurance activity within each service identifies where practice is not meeting expectations. This activity should include relevant specialist services.
- Staff development and training expectations are clearly set out and professional development is prioritised at all levels.
- Supervision provides an opportunity to reflect on any barriers to achieving and maintaining good practice, assists practitioners in thinking clearly in complex cases and identifies learning and support needs.

9 APPENDIX ONE: TERMS OF REFERENCE

Surrey Local Child Safeguarding Practice Review (LCSPR) Terms of Reference (TOR)

Sara Sharif

INTRODUCTION

This review is taking place under statutory guidance set out in Working Together to Safeguard Children 2023. This guidance establishes that the purpose of a Local Child Safeguarding Practice Review is to identify improvements to be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents, and they are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose. As required by the statutory guidance the review will focus on learning for the safeguarding system as a whole and move beyond a description of what happened to a detailed analysis of why events occurred in order to reach recommendations that improve outcomes for children both locally and nationally.

In August 2023 a ten-year-old girl was found dead at her family home. Her father had called the police to say that he had killed her. Following a police investigation in December 2024 her father and stepmother were convicted of murder and her uncle of causing or allowing the death of a child.

Sara and her family had been known to statutory agencies in Surrey and elsewhere, and as a result of her death a rapid review of all information known at the time recommended that there should be a Local Child Safeguarding Practice Review. Due to the complexity of the police investigations and the importance of the criminal justice process in ensuring sustained protection for remaining children, the review was then put on hold at the request of Surrey Police until after the conclusion of the criminal trial.

The rapid review had identified initial learning, and this was taken forward in 2023. Surrey Safeguarding Children Partnership has overseen progress of implementing learning and this review will consider progress in forming final recommendations.

Sara's death has affected public confidence in multi-agency safeguarding practice both in Surrey and nationally. Information from the criminal proceedings and family court proceedings highlights a legitimate and necessary need to understand Sara's lived experience from birth onwards, and to account for actions that were taken to protect her from harm. The review will therefore move beyond a focus solely on recent events to:

- ➢ Gather information about Sara's life from birth up until the Initial Child Arrangement Order in 2019 and analyse what happened when information was known to any agency about potential risks her father posed to women and children, or any concerns about abuse of any child in the family.
- ➢ Provide a detailed analysis of the circumstances of Sara's death, her experience within the family and opportunities to protect her from 2019 onwards.

SCOPE OF THE REVIEW

Time Period

The scope of this review is from Sara's birth through to her death. The methodology for this review identifies how information will be obtained within the two-time frames of:

- ➢ Birth to the Initial Child Arrangement Order in July 2019
- ➢ Her life from July 2019 onwards.

Family Information

The review will request and consider information (in line with the time frame above) in respect of:

1. Sara
2. Sara's siblings and half siblings
3. Mother
4. Father
5. Stepmother
6. Uncle

Constraints

All agencies who knew or worked with Sara and her family will be asked to contribute to the review. However, the review acknowledges the President of the Family Division Guidance: "Judicial Cooperation with Serious Case Reviews" (judiciary.uk) Specifically, "judges do not respond to questions from SCRs, or requests from SCRs to complete IMRs, do not attend evidence sessions or other meetings with SCRs and are under no obligation to provide information to SCRs". However individual Judges can choose to contribute to reviews. This review will consider the role that the judiciary can play in assisting the learning arising from this review as the review progresses.

Key lines of enquiry

The key lines of enquiry will need to be considered throughout the timeframe for review. Some questions are specific to certain stages in Sara's life but many cut across timespans. They have been developed from the analysis within the rapid review and additional information that emerged during the criminal proceedings. They provide a framework for the review but may need to be adapted as further information emerges.

1) What was Sara's lived experience within the family? Particular consideration will be given to:

➢ her experience of significant trauma (past and present)

➢ her experience as a victim of domestic abuse and the impact of this throughout her life

➢ the impact of her stepmother being her main carer and whether this was fully explored in assessments

➢ her experience as a young carer for her half siblings and whether this was fully explored and responded to

➢ the potential for sibling abuse within the family and any impact this may have had on Sara and safeguarding decisions.

2) What actual and/or potential safeguarding concerns were identified by any agency or organisation working with Sara's family?

a. How and where was information about these concerns shared? Were agencies clear about the process for and basis upon which information could be shared?

b. Was information sought appropriately from other agencies in order to inform an assessment of risk?

c. What action, if any, was taken in response to these concerns? Was this an appropriate and reasonable response?

d. If safeguarding partners were concerned about responses from agencies were concerns appropriately escalated and is there evidence that agencies were aware of the process for escalation.

e. If insufficient action took place, is it possible to identify whether there were any particular obstacles to this?

3) What can we learn from the cessation of reports to statutory agencies after Sara moved to live with father and stepmother? Did cessation of reports and positive reports in relation to her siblings create a false assumption that all was well?

4) Were there barriers that prevented Sara from sharing her experience within her family and barriers that prevented anyone who knew her from identifying and sharing concerns about her safety and wellbeing with safeguarding agencies?

5) What role did family culture play in influencing the assumptions of practitioners about child safeguarding? Were there false assumptions about family dynamics, pressures and issues around "honour".

6) Was information about the history of the family shared with relevant agencies and the family courts at the appropriate time? If so, how did any shared information influence assessments and decisions made?

7) What are the facts about any history of domestic abuse and what do we know about any domestic abuse and coercive control at or around the time of Sara's death? To what extent was knowledge in any agency of domestic abuse in past and childless relationships, used to assess safeguarding risks to Sara and other children in the family?

8) How did practitioners apply professional curiosity regarding the parent's decision to undertake Elective Home Education (EHE) within the context of other concerns? Is there evidence that any agency had identified the potential safeguarding impact of this decision?

a. How were agencies other than schools and the inclusion service involved with decision making? Should other agencies have been involved?

b. How did the requirements of local policy and legislation in force at the time influence the potential for identifying the safeguarding impact of the decision to EHE?

c. How far were practitioners aware of the potential for intervention where a child is educated at home and there are safeguarding concerns?

9) How did the elements of race, sex/gender, culture, religion and nationality impact on professional responses to Sara? For example:

a. How were any changes in Sara's behaviour perceived and/or explored?

b. Were practitioners reluctant to explore changes in Sara's physical presentation, including her adoption of the hijab, due to a concern they would be discriminating against this family?

c. Were professionals confident asking questions that relate to matters of culture/religion and was this documented in agencies' case notes?

d. Was there consideration of the role that race/culture/religion might have played in the family response to professionals?

10) Did professionals see/learn anything that should have triggered a higher-level response in response to risk of significant harm?

a. Did Sara communicate her experience of trauma through her demeanour and behaviour? If so, was this recognised by agencies?

b. Were any signs of abuse (physical, sexual, emotional or neglect) recorded and responded to in line with procedure?

METHODOLOGY

The review process is designed to ensure an open and collaborative approach, which is carried out in line with statutory guidance and includes the perspectives and views of family members, practitioners and members of the local community. The aim is to move beyond a sole reliance of professional perspectives and to ground learning in the reality of day-to-day life.

It will follow the framework for reviews established by Surrey Case Review Group, but due to the complexity of this review it is possible that there will be some flexibility required as the review progresses.

Lead Reviewers

To ensure independence this review will be led by two experienced independent lead reviewers, Jane Wonnacott and Russell Wate. As required by statutory guidance the Statutory Partners are assured that the lead reviewers have the required knowledge, skills and experience to lead the review and produce the final report.

The Panel

The lead reviewers will work with a panel who have the range of expertise across agencies and specialisms required. The lead reviewers will meet regularly with the panel as a whole and work with individual panel members to carry out practitioner discussions.

Process

The process of the review will include regular meetings between the lead reviewer and the panel. The following is a broad framework for the review process but may need to be adapted as the review progresses:

1. Analysis of written information already submitted to the partnership via the rapid review process.

2. Informing the family of the review and asking for their contribution when appropriate. At a minimum this will include Mother, Father, Stepmother and Uncle. In relation to children within the family advice will be taken from children's social care as to who should be included and how this should be achieved. The review recognises potential constraints imposed by Family Courts in respect of some children within the family but will aim to work positively with legal systems in the UK and in Pakistan to ensure children's voices are heard should they wish to contribute.

3. Submission of additional information that has emerged since completion of the rapid review. The information will be submitted by individual agencies through:

- ➢ A narrative of work with the family prior to July 2019
- ➢ A detailed chronology of contact with the family from July 2019. This chronology will use the supplied template.
- ➢ Integration and analysis of the chronology by the lead reviewers and the panel.

4. Submission of a factual narrative from all agencies of work with the family prior to July 2019. 5. Production of a detailed integrated chronology of contact with the family from July 2019 through to Sara's death

6. Consideration by lead reviewers and the panel of other relevant reports and documents that may be required to assist learning. These may include (but not be confined to) court bundles and assessments.

7. Identification of key practice episodes to inform discussion with practitioners.

8. Meeting with key practitioners either individually or in small groups in order to move beyond what happened to why events occurred and to share learning and ideas for system improvement. This meeting to be with the lead reviewers and a panel member with expertise in that agency's work.

9. Production of final report agreed with the panel. The process for signing off the report will be in line with Surrey procedures; the report will be agreed with the Case Review Group and then presented to the SSCP Executive

10. Sharing of the final draft with all agencies who have contributed to the review, the family and the National Panel prior to publication.

Legal Advice

Legal advice will be provided to the Panel by Surrey County Council Legal Department who will act on the behalf of the SSCP.