

COURT CASE SCENARIO ANALYSIS

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Court Case Scenario Analysis

Introduction

This paper explores a real-life case from Surrey, England, in which inappropriate social behaviour and domestic violence led to the death of ten-year-old Sara Sharif. Growing up under a father with uncontrollable violent and battering behaviour, surviving her parents' divorce and, after a lengthy legal battle, being placed in the care of her father and stepmother, Sara was systematically beaten and isolated from the outside world. The girl died in August 2023, and her guardians and uncle were convicted of murder and involuntary manslaughter, respectively (Wonnacott and Wate, 2025). The tragic story is not an isolated exception, but shows a structural breakdown in the system that left even the involved agencies and concerned teachers lacking in communication. As a consequence, each agent saw only parts of the big picture, and this contributed to the child's fatal outcome.

This case study is critical because it shows the contradiction in the system of declared values and realised practice. The case shows that even the formally involved mechanisms were insufficient because their application was atomised and uncoordinated. As a consequence, Sara was invisible to the British defence system, and this led to its demise. The aim of this paper is to analyse the impact of British legislation and policies and identify the reasons for their ineffectiveness in relation to Sara's case. In addition, the paper aims to take the conclusions drawn from the tragic story and extrapolate them to other situations in the HSC sector.

Review of the Impact of Legislation, Policy, and Ethical Practices

The Children Act 1989 is the core element of child protection in the UK legal system. Its functional essence is to assign responsibility to local authorities to identify vulnerable children and to conduct thorough investigations where harm is suspected (Department for Education, 2023). At

the same time, the Working Together to Safeguard Children guidelines are responsible for coordinated information sharing and interdepartmental communication (UK Government, 2026). The purpose of these standards is to prioritise the child's welfare over bureaucratic litigation and, therefore, to prioritise the protection of the child, despite all administrative restrictions. However, existing resources proved insufficient in Sara's case.

Decisions were made reactively, and the findings of some agencies were not substantiated and passed on to others. Wonnacott and Wate (2025) show in detail that in the child's case, the safeguarding social agencies were involved, but the level of involvement was formalised. As a result of established practice, the decision to transfer a child from a mother to a father and stepmother with documented mental disorders was made not on the basis of comprehensive data on the father's court appearances and repeated episodes of violence, but on the basis of fragmentary information over time, without dynamics.

Several planes of failure need to be critically discussed in relation to the tragic outcome of Sara. The first is an institutional failure in which public law and private law were formally separated and, as a consequence, valuable information about care proceedings was not integrated into private family proceedings (Griffith and Tengahan, 2023). The lack of regular visits and comprehensive risk assessments, which was compounded by the current quarantine restrictions due to the pandemic (Wonnacott and Wate, 2025), should also fall into this lens. Another lens is ethical failures, according to which there is a perceived gap between the moral responsibility of oversight bodies and the formality of their decisions. World Health Organisation (2026) separately points out that even if the actions of social welfare agents are legally permissible, they can lead to injustice and harm, which is particularly dangerous for vulnerable groups. This was realised in Sara's case, when decisions were made without taking into account the principles of equity and

prevention of harm. As a consequence of the synergy of failures, the actual effect of health and social care was absent or, more accurately, harmful. Real child protection was not realised, and standards of a reasonable practitioner, according to Griffith and Tengnah (2023), were not applied. This was due to bureaucratic formalities and the lack of deep involvement of the staff in charge in the context of the child.

Safeguarding Principles in the Context of the Case

The safeguarding framework is based on several central principles, among which prevention, protection, and empowerment are the most applicable to the case. In general terms, the operation of these principles suggests the need for safeguarding authorities to respond to episodes of child maltreatment and preventative work to minimise initial and repeated scenarios. However, in practice, in the case of Sara Sharif, all three principles have been shown to be deficient in their fulfilment. The prevention principle was not sufficiently realised, as the dynamics of risk assessment were systematically lacking when working with the girl, and the reliance on previous court proceedings was insufficient. For example, a child arrangements order in favour of the father was made by an inexperienced staff member who ignored past incidents and fact-checking. The principle of protection was also minimised in its effect, as even actual manifestations of domestic violence in the form of bruises were recorded by individual participants without coordination or ignored altogether. Finally, the child's empowerment was declarative, and the girl's de facto opinion was not taken into account.

Safeguarding can only be effective when social services and agents of child supervision, including the school, act in concert. In reality, the observations were parallel and did not overlap, creating an atomised view of Sara's life. Professionals had a responsibility to recognise and report signs of abuse and neglect within their roles, and this was indeed carried out. For example, the

teacher noticed and recorded bruises on the girl's face, and health professionals noted the family's vulnerability. In addition, the entire history of violent episodes was available to social workers. However, the pieces of information were not integrated into a holistic picture of risk, allowing violence to continue without protective measures. The lack of a full multi-agency analysis meant that each service saw only a fragment of the situation. An important lesson that emerges from the tragic case described is that safeguarding cannot be effective when, in reality, it fulfils a declarative rather than a protective function. Safeguarding the welfare of the child must be critically and ethically informed, otherwise it has no value.

Application to Diverse Situations

The lessons of the case of Sara Sharif can be applied to situations where a child is transferred to home education after signs of abuse. The applicability is also high to scenarios of private law disputes with power asymmetries between parents. In each of these scenarios, legislation (including the Children Act 1989 and Working Together Guidance) provides legal mechanisms for early intervention. Yet, the application of the law must be accompanied by ethical analysis that considers proportionality and the prevention of harm (World Health Organisation, 2026). Griffith and Tengnah (2023) emphasise the importance of understanding the differences between civil and criminal thresholds of evidence. In simple terms, this enables professionals to be proactive without waiting for sufficient evidence for criminal prosecution. Even if safeguarding and elective home education policies have been strengthened following such cases, their effectiveness still depends on practical implementation. A positive outcome is not guaranteed, and results are determined by ongoing bureaucratic processes and the administrative burden of decision-making bodies. Therefore, social service providers are advised to implement multifaceted family assessments and strengthen interagency strategies to demonstrate professional

accountability and truly achieve positive results.

Conclusion

This paper examined the case of Sara Sharif, who died as a result of systematic disregard for the signs of domestic violence and inadequate protection of a child's welfare. The analysis showed that the fact that legislation and policies are in place does not in itself guarantee the protection of a child. The failure of protection that led to Sara's death was due to the weak application of the law and the atomisation of policy, as well as a complete lack of ethical reflection on decisions. To prevent such tragedies, health and social care professionals must combine legal literacy, ethical responsibility and a human rights orientation. In addition, coordinated inter-agency collaboration and information sharing must be ensured.

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