BURY INTEGRATED SAFEGUARDING PARTNERSHIP

Serious Case Review in Relation to Dina

Final Report

Author: Maureen Noble, Independent Lead Reviewer

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Contents

Glossary/Abbreviations

ABE	Achieving Best Evidence (interview)[1]
C&F	Child and Family Assessment[2]
CE	Criminal Exploitation
CIN	Child In Need (footnote 2)
CSC	Children's Social Care (Children's Services)
CSE	Child Sexual Exploitation[3]
CP	Child Protection (footnote 2)
GCSE	General Certificate of Secondary Education
GMP	Greater Manchester Police
MASH	Multi Agency Safeguarding Hub[4]
MFT	Manchester Foundation Trust
MPS	Metropolitan Police Service
S47	Section 47 (of the Children Act)[5]
SCR	Serious Case Review[6]
UTI	Urinary Tract Infection

[1] https://www.cps.gov.uk/legal-guidance/achieving-best-evidence-criminal-proceedings-guidance-interviewing-victims-and
[2] https://www.proceduresonline.com/bury/cs/chapters/contents.html
[3] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-exploitation/
[4] https://burysafeguardingpartnership.bury.gov.uk/index.aspx?articleid=8925
[5] https://www.workingtogetheronline.co.uk/chapters/chapter_one.html#flow_three
[6] https://www.workingtogetheronline.co.uk/chapters/chapter_four.html

1 Introduction and Background

1.1 Key People Referred to in the Report

Dina – Child who has died

Parents – Dina's mother and father

Dina's siblings are also referred to in the report but not by name, age or gender

1.2 Circumstances Leading to the Review

This Serious Case Review (SCR) is conducted under guidance set out in Working Together (2018) and relates to the tragic death of Dina. The review panel offers sincere condolences to Dina's family and friends on their loss.

Dina died in January 2019, she was 16 years old at the time of her death. The indications are that Dina appears to have taken her own life. The cause of Dina's death will be determined at a Coroner's Inquest. An inquest will take place in November 2019.

Dina's father told police that on the morning of her death he had seen her early in the morning, at around 5.30 a.m., when she had said that she was going out to the gym (this was not unusual for Dina).

Father went to the synagogue and then returned home, he took the other children to school and then went to work.

Mother became concerned as Dina had not arrived at school, she called father and he returned to the family home. When father came back to the house, he decided to look for Dina at a derelict house that was owned by a family member (he later said that he had a feeling that this is where she would be).

Father went to the derelict building which is situated on land close to the family home, and found Dina's body there. He found her suspended from the ceiling by a rope, she appeared lifeless. Dina's father cut the ligature from which Dina was suspended and placed her on the ground. He tried to resuscitate her without success.

Police and Ambulance services were called to the scene, where it was confirmed that Dina had died.

Dina's parents contacted school to let them know of her death.

A police investigation was commenced. A man was questioned and released without charge. The police investigation concluded that there were no suspicious circumstances associated with Dina's death and the investigation into her death was closed.

On examination of Dina's phone by police, pictures of a 'suicide note' were found, which were in Dina's handwriting. In the note Dina had written that she intended to take her own life and that, by the time her parents read the note, she would have done so.

The contents of the note set out Dina's thoughts and feelings about a number of things that had been troubling her over several years. Dina made reference to her desire to end her life,

she described feelings of low self-esteem, issues relating to her body image, concerns regarding her academic achievements, difficulties with inter-personal relationships and a brief reference was made to Suspect 1 (see below).

1.3 Synopsis (Overview of Dina, Events and Agency Involvement)

Dina was the second oldest child in a family of six siblings. She lived with her parents and siblings in the family home and attended a local school. The family are members of the Haredi Jewish Community[7]. The local Haredi community is a relatively small and close knit community, which is concentrated in an area of the Borough that is primarily occupied by communities belonging to the Jewish faith and culture.

As an infant, Dina was diagnosed with a chronic health condition for which she took medication and had regular appointments with a specialist service. Dina's condition appears to have been well managed, and in the 2 years prior to her death had been assessed to be in remission. Until Dina's care was transferred to a local (Bury) service in 2016, the family engaged well with the specialist service and assisted in managing Dina's condition.

At aged 4 years 8 months, Dina was referred by the family GP to Royal Manchester Children's Hospital (RMCH) after having a one-year history of urinary tract infections. Dina was seen at RMCH. Records indicate that an ultrasound scan was undertaken and that all was 'normal'. The parents and GP were notified of the outcome of the ultrasound scan and were informed that, if there were any further concerns, they could contact the Consultant[8].[9]

From 2016 onwards, Dina reported to the specialist medical service that she had been relatively free of pain and was doing well. There had been discussions with Dina regarding medicines administration as she transitioned from childhood to adulthood. Again the family were supportive and engaged with services, however, at the point of transition to the Bury Community Health Service the family appeared to disengage. The review learned that Dina did not talk about her condition very much and tried to get on with her life in as normal a way as possible.

In the eighteen months prior to her death, Dina experienced a number of difficulties with her emotional health and wellbeing.

Dina had begun to experience difficulties at school and had fallen behind with school work. The review cannot speculate as to whether Dina's declining performance at school was related to other difficulties she was experiencing, but this would not be unusual and is supported by published research (an example of which is provided for reference).[10] Dina worked hard to catch up with her studies. Dina asked her parents to arrange private tuition

[7] See 'cultural context' and Appendix 1
[8] https://www.nice.org.uk/guidance/cg54/chapter/Recommendations
[9] https://www.nice.org.uk/guidance/cg54/evidence/full-guideline-pdf-196566877
[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/219638/DFE-RR253.pdf

to help with her studies. They agreed to do this and brought in a private tutor to work with her.

During the first part of the period under review in this SCR, Dina attended a local Orthodox Jewish school (referred to as School 1), which is located in the Salford local authority area, where she had a strong friendship group (the review learned that Dina was friends with a group of girls who were experiencing emotional health difficulties). In November 2017 one of Dina's peers was hospitalised due to self-harming. Dina offered support to the young person, although this caused some consternation with the young person's parents. This was dealt with by School 1 as a pastoral matter.

In January 2018, Dina's parents decided to move her to School 2 (which is located in the Manchester local authority area). Dina's sibling also moved to School 2 at the same time. Dina's parents felt that she may benefit from a changed environment and a fresh start. There were no concerns raised by School 1 about Dina's mental or emotional health whilst she was a pupil there. School 1 said that they did not have any safeguarding concerns to pass on to School 2 in relation to Dina.

Following the change of schools, Dina's behavioural issues appeared to deepen and her parents' concerns about her increased. It appears that Dina remained in contact with friends from School 1, she later told a professional that she was angry about being moved to School 2.

Dina was active on social media, although her ultra-orthodox culture forbids the use of mobile phones and social media. This was an issue of contention at school.

Dina was described by her parents as a strong and forceful character who felt that she knew best, and knew her own mind. It is clear that Dina had begun to test boundaries with her parents and in school and social settings. There are indications that Dina's parents had struggled with her challenging behaviour for some time. They had sought support from friends and services in the orthodox Jewish community.

Others who knew Dina described her as a strong character who presented as being confident and outgoing. School 1 said that she could be stubborn and resistant, particularly if she did not agree with what she was being asked to do. She had aspirations to enter the medical profession and was said to be determined and hard-working in relation to her studies.

In May 2018, Dina was referred by a family friend to a local counselling service, Keren, who work with young people from the Orthodox Jewish Community. At that time Dina said that she did not want help from the service as she had friends that she could talk to. However, her mother felt that she would benefit from the service and persuaded her that she should attend the service, which she did.

At this time Dina had begun seeing a private therapist however, although she attended a number of sessions with the therapist, the therapist told the review that Dina had said she did not want to talk about any aspect of her life.

Dina sometimes travelled unaccompanied to London to see friends and family and had the permission of her parents to do so. However, at the end of June 2018, Dina went to London without her parent's permission.

On her return she was questioned by her mother who found a large amount of cash, a quantity of white powder, a fake ID and the emergency contraceptive pill in Dina's bag. When mother questioned Dina about this she said that the white powder was cocaine, and that she had met a man with whom she had had sex.

Mother contacted Keren about this and in June 2018, during a home visit from the safeguarding lead at Keren, Dina disclosed that she had been 'seeing an 'older man' in London (later known to be Suspect 1). She said that she had had sex with him. She also disclosed that she had taken drugs. Following this disclosure Keren made a safeguarding referral to Children's Social Care (CSC). This referral started a period of involvement with statutory services.

The review learned that Dina disclosed[11] suicidal thoughts (ideation) to her family and to a number of professionals. She told her parents that she had attempted to take her own life on at least one occasion.

She also disclosed self-harm to the private therapist. She said that she had taken a large quantity of cocaine, but this had not had the anticipated effect (she had said that she wanted to induce a heart attack).

She told professionals that she had purchased drugs (cyanide)[12] from the internet with the intention of using this as a means to end her life. Dina later told professionals and her family that she had made these things up, however the indications are that Dina had previously attempted to take her own life on at least one occasion.

Following a period of sporadic contact with CSC between July and November 2018, during which Dina was classed as a Child In Need (this requires voluntary engagement and consent from parents), CSC closed the case as Dina did not want to engage and her family reported that things had begun to improve. They said that they did not feel there was a need for them to be involved with CSC. Dina was advised that she would remain 'open' to the Complex Safeguarding (CSE) social worker as a police investigation into possible CSE was ongoing (this is usual practice).

NB: As part of the police investigation following Dina's death, material was recovered from Dina's mobile phone which indicated that Dina had harboured thoughts of self-harm and suicide which she shared with friends on social media. This led to concerns that Dina may have been involved in a 'suicide pact' (potential suicide cluster/contagion[13]). This report provides a summary of these events (which were unknown to agencies prior to Dina's death)

[11] https://papyrus-uk.org/im-a-professional-1-2-1-advice/disclosure-of-suicidal-thoughts/
[12] https://www.healthline.com/health/cyanide-poisoning
[13] https://www.nice.org.uk/guidance/ng105/resources/preventing-suicide-in-community-and-custodial-settings-pdf-66141539632069https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769469/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf

but does not analyse them in detail as they are post-death and outside of the remit of the review.

The review panel made enquiries and was satisfied that appropriate action had been taken to safeguard other young people known to have been involved in social media conversations regarding cluster suicide.

This report sets out the key events that occurred in the period under review. These are set out in chronological order in Section 3, and analysed for learning in line with the agreed terms of reference of the review.

It is important to note that Dina did not always share what was happening in her life and there are likely to be aspects of Dina's daily lived experience that were not known to agencies at the time and are therefore not known to the review.

2 Review Methodology and Parallel Processes

2.1 Decision to undertake a Serious Case Review

On 11th February 2019 the Bury LSCB Case Review and Learning Sub-Group held a screening meeting to discuss the case. At that meeting it was unanimously agreed that a SCR should commence.

The Bury LSCB appointed Maureen Noble as Independent Reviewer and the review commenced in March 2019.

A Serious Case Review Panel was convened, the first meeting of which took place in April 2019. The Panel agreed the parameters for the review and drew up a terms of reference, set out below.

Dina's parents were notified in writing of the review and invited to participate. Interactions with Dina's parents and their views are included throughout this report. As is usual the name of the deceased child is anonymised in this report, the anonymised name Dina was chosen by the family.

Please note, the Bury LSCB was disestablished on 30th September 2019, the Safeguarding Partners have taken the decision to join the functions of both the Bury Safeguarding Children Board and the Bury Safeguarding Adult Board to create a new partnership. This final report has been published by the recently formed Bury Integrated Safeguarding Partnership (BISP).

2.2 Period under review

The panel agreed that the review should focus on the period August 2017 to the date of Dina's death in January 2019.

Relevant historical events and contextual information are included in this report but are not analysed in detail.

2.3 Links with the 'Daniel' Serious Case Review

It was noted by the panel that the LSCB had recently commissioned a Serious Case Review in relation to a young person thought to have taken their own life. The young person was from the same community as Dina and, although there is no information to suggest that there was any link between the subject of that review (referred to as Daniel) and Dina, the review was cognisant of the 'Daniel' review, and it was agreed that there would be a consistent approach to describing aspects of culture, ethnicity and identity across the two reviews where this was relevant and appropriate. It was also agreed that, if similar recommendations were noted across the two reviews, that these be highlighted and, as far as possible, not duplicated.

It is important to highlight that, whilst Dina and 'Daniel' are from the same community Dina's daily lived experience was unique to her and has been explored fully in order to learn about how aspects of Dina's life such as culture, ethnicity and identity may have influenced her interactions with agencies, with her family and with her peers.

2.4 Terms of Reference

The panel agreed the following terms of reference for the review. These were finalised following a meeting with Dina's parents and were shared with them.

1. Did agencies seek opportunities to understand and act on Dina's feelings about her daily lived experience? How did they do this; what was the outcome?
2. Were agencies aware of issues in relation to suspected child sexual exploitation (CSE), if so what action did they take and what was the outcome?
3. Did agencies give consideration to Dina's mental health needs; was mental health screening and referral considered? If not, why was this?
4. Were agencies aware of Dina's suicidal ideation? [14] What did they do about this and what was the outcome?
5. How did agencies involve Dina's family; was this successful in improving outcomes for Dina? Were there any barriers encountered by agencies in this respect (for example CSE, diversity, resistance to engagement with services by Dina or her family). How did agencies address these barriers?
6. Did agencies take account of equality and diversity (culture, ethnicity, religion) when addressing Dina's needs. What impact did equality and diversity have on agency practice or direct work with Dina?
7. How did agencies work together, both generally and on specific issues? Are there examples of good practice in relation to interagency working? What lessons can be learnt?

The review panel identified four key time periods on which the review would place detailed focus as follows:

[14] http://documents.manchester.ac.uk/display.aspx?DocID=37566

1. December 2017/January 2018 when Dina moved from School 1 to School 2 with specific focus on the reasons for transfer, the transfer process and any safeguarding issues identified
2. January 2018 to July 2018 when Keren made a referral to CSC with specific focus on events in Dina's life and opportunities for intervention
3. August 2018 to November 2018 when CSC were involved with specific focus on engagement, interventions and case closure
4. December 2018 to Dina's death with specific focus on key events and agency involvement

2.5 Police Investigation into Dina's death (Greater Manchester Police)

As referenced in the introduction to this report, following Dina's death a police investigation was commenced. A man was questioned and released without charge. The police investigation was then closed.

2.6 Criminal Investigation – Suspect 1 (Metropolitan Police)

Running parallel to this Serious Case Review, the Metropolitan Police were investigating Suspect 1 for crimes against children.

In December 2018, Dina provided an Achieving Best Evidence (ABE) interview at Bury Police Station (attended by Metropolitan Police Officers) at which she described sexual activity with Suspect 1 that confirmed that Dina was in fact under the age of 16 when this activity took place.

Suspect 1 was arrested and was subsequently charged with sexual offences against children, one of whom was Dina.

In July 2019 Suspect 1 was found guilty of several charges of sexual offences involving children, one of whom was Dina.

2.7 Coronial Matters

An inquest has been scheduled to take place in November 2019.

A final draft of this report has been provided to the Coroner.

2.8 Cultural Context

As referenced above, Dina belonged to the Haredi Jewish Community and lived in an area of the Borough largely populated by members of that community.

The Haredi community is an Ultra-Orthodox Jewish community. The term Haredi or Charedi is derived from the Hebrew for 'fear' and can be interpreted as 'one who trembles in awe of God'.

The residential preferences of the people of the Haredi community are strongly influenced by their desire to belong to a kehilla, a local and autonomous group of people who share their theological outlook, culture, and traditional attitudes towards religious observance. The Haredi community follow the guidance of their religious leaders, who act as spiritual

guides and educators and their religious ideology regulates the observance of the Sabbath, the preparation of kosher foods, social interaction between men and women and many other aspects of their day to day lives.

Dina's mother told the review that she was concerned about the family getting involved with CSC and that she did not feel that services understood the Jewish/Haredi culture. Both parents said that they had done their best to engage with the mainstream public services offered to them.

It is clear that in relation to health services provided to Dina for her ongoing medical condition, the family engaged with services. They also spoke to their GP about concerns for Dina.

In relation to responding to Dina's difficulties at school and concerns regarding her emotional health and wellbeing, the family and school sought services from within their community. This is of course a matter of personal choice. However, the review draws conclusions around the need to strengthen relationships and pathways between these services and what may be considered 'mainstream' public services, in both the statutory and non-statutory sectors.

The review noted that there is a tendency towards larger family size within the Haredi community, with many married couples starting a family at a young age. This can lead to financial hardship in some families and large family size may increase pressures on parents.

2.9 Family Involvement in the Review

The BSCB Business Manager wrote to Dina's parents in April 2019 to inform them that a SCR was taking place and to invite them to participate.

Parents kindly agreed to contribute to the review. The lead reviewer and a member of the review panel met with Dina's parents at the family home.

A summary of the key points raised by parents and the information by them at the first meeting is set out below.

Parents were strongly of the view that Dina had not been treated as a victim of CSE by CSC and by individual staff in the Complex Safeguarding Team. They felt that Dina had been seen as a 'naughty child' rather than a young person with vulnerabilities who was at risk of exploitation.

They raised particular concerns that they wanted the review to address, including the following:

The use of what the family described as 'threats' made to them and Dina when the case was closed by CSC in November 2018.

Why services did not recognise Dina's previous suicidal thinking and risks. Linked to this why Dina did not receive screening for referral to mental health services?

The quality of the liaison and joint working between local services and the Metropolitan Police.

These concerns were noted and reflected in the Terms of Reference for the review.

Both parents said that they were not the type of family who were unwilling to be involved with services and that they had tried to engage.

Dina's parents were critical of the approach taken by CSC and the Complex Safeguarding Team. It was their view that there was little understanding, or attempt at understanding, of Dina's cultural background and her faith.

Mother was particularly critical of the materials used in relation to describing healthy sexual relationships (Real Love Rocks). She felt this illustrated a fundamental lack of understanding of the behaviours expected of a young Orthodox Jewish girl who had been raised with specific values and codes of conduct in relation to sexual relationships before marriage.

Parents said that Dina was a strong person but that she had vulnerabilities. Dina had spoken to her mother about being bulimic, although mother said that she did not think that Dina was bulimic, but that she did have low self-esteem in relation to her appearance, despite Dina being a 'beautiful and bright girl'.

They spoke about Dina's education and her academic ability. They said she had experienced some behavioural difficulties at School 1, and they felt that this was beginning to negatively impact her academic performance. Dina had always wanted to enter the medical profession and worked very hard to achieve in school, although her performance had begun to suffer. Dina's parents engaged a private tutor to work with her to support her academic studies.

Following the move to School 2, Dina continued to experience difficulties with behaviour in school, although her attendance was reasonably good. Parents were aware that Dina was continuing to have difficulties and that she had not settled as well as they hoped into the new school.

Dina participated in family life and continued to help her father in his business as she had always done. She put a lot of effort into catching up with her studies and sometimes stayed awake late at night doing homework.

When parents became aware that Dina was "seeing a man from London", they tried to get counselling support for her from local services, although Dina was reluctant to engage. Throughout the months that followed, the family tried to seek appropriate advice and support for Dina, although mother did not feel that CSC understood the family and therefore was reluctant to maintain contact with them.

Parents commented on the support that they had received from officers in MPS and that they felt that this was the only consistent source of support that they received from statutory agencies.

The Lead Reviewer met with Dina's parents towards the end of the review to discuss the conclusions and recommendations of the review and to seek feedback from them. At this

meeting parents reiterated that they felt services had not understood Dina's culture and that this had been a fundamental problem throughout their contact with services.

They stressed that Dina did not want services in her life and that any escalation of involvement would have only created more pressure on Dina.

They also felt strongly that Dina did not receive the support that she needed when she had given the ABE interview in relation to the criminal case involving Suspect 1. They felt that this would have been extremely difficult for her, as it involved her revisiting traumatic events and also realising that it may adversely affect her future. (This supports the view of the panel that the impact of the ABE was underestimated and that appropriate support was not in place).

They reiterated that they could not understand why agencies did not 'pick up' on Dina's self-harm and suicidal actions and thoughts; nor could they understand why no-one had thought about referring Dina to Child and Adolescent Mental Health Services.

3 Agency Involvement with Dina – Timeline Of Key Events

NB: Dina and her family had contact with four social workers during the period under review. It is not unusual for more than one social worker to be involved with a child and their family in cases such as this. To assist the reader the four SWs and their respective functions/teams are referred to as follows:

SW1 – The first Social Worker to work with Dina, a member of the Complex Safeguarding Team

SW2 – The social worker who was allocated to conduct a Child and Family Assessment with Dina.

SW3 – A Social Worker from the Initial Response Team who was allocated to the case.

SW4 – The social worker who replaced SW3

3.1 Key Events in 2017

In September Dina saw the school counsellor at School 1. At the session Dina disclosed that she was unhappy at school and that she was 'fussy' about what she ate.

The school has a mentoring system and Dina was mentoring someone whom she said was self-harming. Dina did not make any disclosures regarding personal self-harm.

In December Dina was spoken to in school regarding a young person who had been hospitalised due to self-harm. Dina had sent an 'inspirational' song to the young person via social media and felt that this was supportive. The young person's parents were unhappy that social media was being used and did not want Dina to have further contact. School gave guidance to Dina regarding boundaries and the use of social media. During the meeting Dina did not make any disclosures regarding personal self-harm.

Around this time School 1 were informed that Dina's parents wanted to move her and a sibling to School 2. A school transfer took place in January 2018, which is detailed later in this report.

The Local Authority were not involved in the transfer. School 1 stated that they had not identified any safeguarding issues to pass on to School 2 at transfer.

3.2 Key Events in 2018

When Dina moved to School 2 it was recognised that she needed additional support due to changing schools part way through the academic year, as she was preparing for GCSE courses.

In February the school secretary at School 2 contacted School 1 to request information about Dina, however they did not receive a response.

In May 2018 a friend of the family made a verbal referral for Dina to a local support service (Keren). Keren is a registered charity that supports Jewish young people in the local area. The referral was related to Dina struggling academically and wanting to leave school.

The referral included information that there were problems in relation to boundaries at home, and inconsistencies in Dina's behaviour. The referrer said that Dina was challenging her cultural upbringing; that she continued to have a phone (although School 2 had been told that she would give this up), and that Dina's parents had little control over her.

The referrer said that although Dina was not suicidal she had said that life 'didn't mean anything to her, and she had a very bleak outlook'. The referrer said that Dina had no routine and no structure, that she was on her phone all night and that attendance at school had started to drop. The referrer said that Dina was 'struggling with mother', as Dina did not feel that she was understood at home.

During the conversation the case manager at Keren asked about support for parents, the referrer said that she was supporting them.

The case manager agreed to take the referral to the Keren team. On 4th June the team held a discussion regarding the allocation of a key worker. On 7th June the referrer contacted Keren to say that Dina did not want to attend the service as she did not feel she needed any help.

This was followed on 10th June by a contact to Keren from Dina's mother saying that she had persuaded Dina to attend (although Dina didn't want to do so), and an appointment was made for Dina and her mother to meet with a key worker from the service.

On 14th June Dina attended Keren with her mother and saw a key worker. It was noted that Dina attended reluctantly.

It was noted by Keren that Dina seemed comfortable and that she understood why she was there. Dina said that she didn't need anyone in the service to talk to. She said that she had friends and didn't need anyone else.

During the session Dina was asked about what kinds of things she liked, she discussed school and was offered the opportunity to get involved in art sessions at the service. Dina told Keren that she wanted to leave school as soon as she could and that she was interested in joining the British Army (NB: mother reflected to the review that she didn't believe this was what Dina really wanted, but that she knew it would cause a reaction).

Towards the end of the session it was noted that Dina began to relax and talk more openly. Following the session it was agreed within the service that they would be able to offer support via a key worker and that this would be beneficial for Dina.

On 18th June the worker from Keren met with a private therapist and discussed the option of family therapy for Dina and her family. The following day work began on allocating a key worker and communicating with Dina's mother to arrange an appointment.

On 27th June Keren received a call from Dina's mother. She was concerned as Dina had gone to London (without permission) to stay with a friend overnight. Dina had returned on the first train back to Manchester.

Mother said she was worried and went through Dina's bag whilst Dina was in the shower. Mother found a large amount of cash and a quantity of cocaine, she also found a fake ID and the emergency contraceptive pill.

When mother questioned her Dina she said that she was safe and there was nothing to worry about. Dina then told mother that she had had sex a few times and that the man wasn't from Manchester. Dina told her parents that she had saved up the money to buy an iPhone and that she had tried to use all of the cocaine (seven grams) but could only manage to take three grams. She refused to say any more about the man. Parents removed Dina's phone and took her to school.

On 28th June the Keren worker discussed mother's call with her manager and it was agreed that a referral should be made to Bury Children's Services (CSC), as Dina was deemed to be at risk of significant harm.

The referrer (a family friend) visited Dina at home on 29th June 2018. Dina stated that she had tried Cocaine once and used three grams. She said that she was aware that seven grams can kill you and therefore she had wanted to take it all, as she wanted to kill herself. She said she had also tried to slit her wrists.

Dina said that she had ordered Cyanide tablets from the internet to kill herself and taken them. Later she said she was only joking and had taken almonds. Dina reiterated that she wanted to end her life as it 'is not worth living'. She also stated that as soon as she turned 16 years old she would be leaving home and joining the British Army.

The key worker called mother to tell her that a referral was being made to CSC and mother said she was in agreement. A few moments later mother sent a text message asking Keren not to make the referral to CSC

Following this message the key worker spoke to a friend of mother's to explain why it was necessary to make a referral the referral. The friend said that they (she and mother) were

concerned that CSC would not understand how to deal with the family. Mother was also concerned that Dina may get a criminal record.

The Keren worker spoke to CSC who advised that a referral should be made and reassured regarding concerns about a criminal record. Mother was informed of the referral by Keren and agreed to it, the referral was then made online.

Mother left a number of messages with Keren later that day to say that the family did not want CSC involved.

On 30th June, Dina went to the referrer's home address to apologise for her behaviour during the home visit the previous day. Dina's parents also attended. Dina's parents informed the referrer that she was no longer seeing the male (suspect 1), and said that they believed everything she was telling them. They said they felt that they had put boundaries in place to manage the situation e.g. an 11pm curfew amongst other measures

On 2nd July the referral made by Keren was screened by Bury CSC Complex Safeguarding Team and the case was allocated to SW1. Three days later a referral was received by the MASH which was allocated to SW2 for C&F assessment on 10th July.

On 5th July a professionals meeting took place. Following a referral to the Bury Multi-Agency Safeguarding Hub (MASH) the Manchester School Nurse (MSN) became aware that Dina was attending a Manchester school. The MSN attended the professionals meeting (which MSN had originally believed was a Strategy Meeting). MSN was informed at that time that Dina had transferred schools in January 2018, as Dina's academic performance had declined at her previous school. (NB: the MSFT report indicates that the timescale and precise details of Dina's self-harm as well as details of the referral were not shared with the MSN at this time). It is not clear in the records why MSN was not notified sooner by School 2 that Dina had changed schools earlier that year.

Following the meeting held on 5th July, MSN contacted Manchester Foundation Trust (MFT) Safeguarding Team for advice, and subsequently contacted the MFT Child Sexual Exploitation (CSE) nurse. The Manchester CSE nurse had no record of Dina. The CSE nurse gave advice to MSN and made a record of Dina in case any future concerns were raised in Manchester. There was a missed opportunity here to liaise with the Phoenix/Complex Safeguarding Team in Bury, which would be expected practice.

MSN contacted the previous authority (Salford) for the school health records. NB The records were not accessed until 12th June 2019, after Dina's death. MSN also contacted the Practice Lead for Safeguarding at Dina's GP. MSN was informed that the family had recently changed GP practice as the previous GP practice had closed.

The GP confirmed that the surgery had not prescribed emergency contraception, nor had they undertaken urine testing. (This appears to contradict information provided by mother to School 2 regarding these events). The GP agreed to arrange a new patient health check and said that they would record Dina as being vulnerable.

Three meetings then took place in quick succession, these were on 12th July, 13th July and 17th July.

MSN noted in the records that a strategy meeting took place on 12th July, however, there were no minutes from this meeting on the CSC records, and it has not been possible to identify the actions required from this meeting or who was in attendance.

On 13th July SW2 undertook a home visit at which parents agreed to a C&F assessment in relation to Dina taking place. Parents said that they accepted that Dina needs support. They said that they had thrown away the substance found in Dina's bag and did not now believe this to be cocaine. They reported that Dina had a job in the family business and could have saved up money, as she doesn't spend much of the money she earns. Parents reported that they had sought support from agencies within the community and were working with school who had been supportive.

On 17th July, a strategy review meeting was held**.** The actions agreed were to speak to Dina at school that same day and that a health care plan should be completed by school, including an assessment of self-harm and to speak to the GP regarding a general health assessment.

A plan was made by the MSN to complete a health assessment with Dina. It is noted on the records that, as it was at the end of the school term and the long summer holiday was imminent (the next day), the health assessment should be undertaken in the next school year.

That same day SW1 and a Detective Constable from the Bury Public Protection Unit visited School 2 to speak to Dina. Dina told them that she regularly goes to London to see friends or family and that her parents were aware of this, other than on the last occasion (27th June). Dina said that she is friends with a male taxi driver. She said that she had not had sex with him, and said that she was not sexually active. Dina said that she had not told the truth about the 'drugs' that mother had found and that the white powder was talcum powder, not cocaine.

On 26th July SW1 and SW2 conducted a joint home visit to see Dina at which both parents were present. At this meeting Dina said that she did not want to engage with CSE work, although father appeared to welcome their involvement and felt that this could replace work with the therapist (who Dina was seeing privately). SW1 and SW2 informed father that this would be a different type of work. Dina remained reluctant to engage but appeared to welcome the idea of not having to see the therapist if she engaged with the CSE Team.

On 29th July, Suspect 1 attended a police station in London and told police that he was wanted by Greater Manchester Police (GMP) for the rape of a girl (later established as Dina). He said that he had been told 'by someone' that the girl's parents had reported him to GMP. MPS contacted GMP to check whether they were aware of the allegation. MPS recorded that GMP could find no record relating to the allegation against Suspect 1 in relation to Dina.

On 30th July a CSE risk measurement tool was completed which scored as high risk. Dina did not participate in the completion of the risk measurement tool, it was completed based on information from a range of sources and based on professional judgment. This is not unusual practice.

Concerns were noted regarding a lack of parental supervision and a number of discrepancies with information provided by Dina and parents. This lead to the conclusion that Dina was at increased vulnerability with regard to exploitation and abuse.

When spoken to about the perceived risks, Dina did not appear to recognise the risks associated with her behaviour. It was deemed that Dina required intervention from the Complex Safeguarding Team (who provide interventions related to CSE) to assist her in understanding these risks. SW1 was allocated to work with Dina in relation to CSE risks. It was also agreed that Dina was to remain open to CSC as a Child in Need.

On 17th August SW1 visited Dina at home. SW1 observed that Dina appeared to dominate her parents and noted a lack of boundaries. It was also noted that Dina was very resistant to involvement with the service.

On 22nd August SW1 undertook another home visit and noted a more positive response from Dina, although Dina was still very resistant to engaging with the CSE work.

The following day a further home visit was undertaken with SW3 from the Initial Response Team. At this meeting mother agreed to family support and Dina agreed to attend Child in Need meetings.

On 4th September the C&F assessment was completed and recommended Child in Need.

That same day GMP received an intelligence report from the MPS stating that on 29th July in the early hours of the morning a male attended the front office of a London police station regarding an allegation of rape.

On 10th September SW3 made a referral to a family support worker for parenting support.

On the 13th September officers from MPS, accompanied by SW1 visited Dina at school. Dina was asked about contact with Suspect 1 and made no disclosures. Dina's I-phone was seized with mother's consent (this phone had previously been confiscated at school).

On 14th September Suspect 1 was arrested. He was bailed to come back to court on 12th October.

On 18th September GMP officer, at the request of MPS, attended Dina's home address and seized a second mobile phone belonging to Dina.

On 24th September SW3 emailed the head-teacher at school to arrange a CIN meeting as there had been no response to previous messages.

On 3rd October SW1 and SW3 conducted a joint visit with Dina. Dina had agreed to the meeting but was described as being very guarded and giving only 'one word answers'. Dina reiterated that she absolutely refused to engage in 'keep safe' (CSE) work.

That same day SW1 received a phone-call to say that Dina would engage with CSE work rather than engaging with the therapist (it appears there was a six months waiting list to see the therapist).

On 4th October a CIN meeting took place.

On 8th October Dina sought advice from the school nurse as she was experiencing stomach cramps. Mother came into school to collect her and told the school nurse that Dina had a further appointment with the CSE team and that Suspect 1 had been arrested in London.

On 9th October officers from MPS again visited Dina, again she did not make any disclosures. MPS Officers met a GMP officer and SW1, and updated them on the current situation. Officers also obtained a written witness statement from Dina's mother.

On 11th October SW1 saw Dina at school for a direct work session. Following the session mother rang CSC and appeared anxious about SW1s involvement.

On 22nd October SW1 conducted a direct work session with Dina at which it was noted that Dina appeared to show more interest and the session was said to be positive.

The following day parents attended an office visit with CSC at which they agreed to take Dina's phone from her every evening (Dina was thought to have a new phone). Father advised that he had frozen Dina's bank account and that a friend of the family was assisting in mediating with mother and Dina, which mother reported had been very helpful. They had set up a contract of expectations, however Dina had broken this and privileges had been withdrawn.

On 25th October the case was transferred to a Safeguarding Social Worker (SW4).

On 31st October SW1 undertook a direct work session with Dina at which Dina was reluctant to engage and her behaviour was noted to be 'completely different' from the previous meeting.

On 8th November SW4 conducted a home visit at which parents were said to be cooperative and engaged. They shared the view that Dina was now more settled and that support was no longer required. It was also evident that Dina did not wish to engage with services in relation to CSE.

On 12th November MSN undertook a health assessment with Dina. The assessment was thorough in relation to physical health. MSN asked Dina about drugs, alcohol and sexual health. Dina appears to have minimised recent events in relation to CSE. Dina denied any sexual activity and said she had not taken drugs and that she had made things up to scare her parents.

MSN asked about suicidal thoughts to which Dina said that she did not feel depressed, she said that she experienced mood swings. Dina denied having taken an 'overdose' of cocaine, and said that what she had used was actually talcum powder. She said that she sometimes felt stressed regarding school work however she said that never tried to self-harm. MSN

noted that her impression was that Dina was not open in answering questions and that there were contradictions in what agencies knew and what Dina was saying to MSN.

As set out earlier in this report, around this time a peer of Dina's at School 1 was hospitalised due to a self-harming event. Dina offered support to the young person which resulted in the young person's parents speaking to school about the appropriateness of the support Dina had offered.

On 20th November a CIN meeting took place which was attended by Dina's, her parents, CSC, School 2, MSN. It was agreed at this meeting that the case would be closed to CSC. The reason for this was recorded as both parents and Dina having said that they did not want CSC involvement as it was no longer necessary. Dina said that she did not want to engage with the CSE worker (SW1) and would not meet with them, even on an ad hoc basis. MSN noted that Dina was direct and forceful in relation to engagement with services.

MSN and CSC records note that the meeting agreed that any future concerns would be escalated to Section 47.

On 30th November MSN discussed Dina in safeguarding supervision. MSN raised concerns regarding parental resistance to involvement with services, and that Dina had not been completely open during the health assessment. It was noted by MSN that Dina was not consistently engaging with CSE work and that the case had been closed by CSC. The plan was that Dina be made aware that she could continue to access services for support for CSE and that professionals should be alert to any future concerns. There is no indication in the records that MSN considered challenging the decision to close the case, despite their concerns.

Further there is no evidence of any consideration regarding referral to drug services, despite Dina's disclosure regarding drug use.

On 2nd December MPS officers re-attended Manchester after they received information stating that Dina wished to talk with them. An Achieving Best Evidence (ABE) interview with Dina took at Bury Police Station (GMP). The interview was facilitated by officers from GMP, although they were not involved in the interview itself.

During the course of the ABE interview, Dina provided disclosures in relation to sexual activity with suspect 1. MPS recorded that they provided a full update of the interview to GMP and to Bury Children's Services.

There is no record of professional support being available or offered to Dina by any agency immediately following the ABE interview. This is a significant missed opportunity to offer emotional and practical support to Dina following what must have been a traumatic experience for her. This may also have provided an opportunity to try to re-engage Dina in support services.

It would have been good practice to hold a multi-agency professionals meeting at this point to review Dina's needs.

Suspect 1 was arrested on 6th December 2018.

In December 2018, the specialist nurse (in relation to Dina's medical condition) was contacted by Dina who queried a dosage change and was anxious about it. The changes were explained to Dina and a plan was made to see her on 7th January 2019. Mother later contacted the nurse as she was unable to keep the appointment due to child care responsibilities. Dina was then referred to the local Bury Children's Community Nursing Team to help Dina and parents understand the medication administration change so that they would be confident in the prescribed treatment. Both Dina and parents were satisfied with the plan however they did not make contact with the Bury Children's Community Nursing Team (CCNT).

On 7th December, Suspect 1 was charged with several offences against children and remanded in custody. He appeared at Crown Court on the 4th January 2019, and was again remanded until trial.

A letter was sent to Dina on 14th December by SW1 to inform that the case had been closed. CSC had no further contact after this date. The letter said that Dina could still access support in relation to CSE if she wished to do so.

On 17th December Dina attended a sexual health clinic with a suspected urinary tract infection (UTI). MSN was notified however it was not clear whether treatment had been provided or whether the MSN offered any follow up, given the concerns previously raised around CSE.

3.3 Key Events in 2019

On 25th January Dina attended a school residential weekend. Staff discovered that Dina had been smoking cannabis. They planned to telephone Dina's parents the following day (it was Shabbat and therefore there was a delay in contacting them). The review noted (and this was confirmed by parents) that it is usual for members of the Orthodox Jewish community to have no external contacts during the period of Shabbat, and that parents would not have answered any phone-calls during this time. (NB This raises a significant dilemma in relation to safeguarding and/or emergency contacts during periods of observance which will be discussed with the relevant bodies involved in implementing the recommendations of this review).

Dina was due to attend a meeting about the incident in school on the morning of 28th January (when speaking to the review father referred to this as a disciplinary meeting). School 2 has a policy in relation to pupils found to be using drugs and said that this was what was going to be discussed with Dina.

On the morning of 28th January MSN was made aware of emails that Dina relating to the incident that took place on the residential trip.

Although the presenting issue was in relation to the use of drugs, there is no indication that consideration was given to Dina's wider known vulnerabilities as a factor in whether to contact parents. Nor is there any indication that consideration was given to making a safeguarding referral to CSC. It was the view of father that information about Dina's was not

shared sufficiently with staff outside of the safeguarding team, and therefore some members of staff were not aware that Dina was a victim of CSE.

On 28th January Dina's father telephoned the CSE team at MPS reporting that Dina was missing. He was advised to report Dina missing to the local police, which he said he had already done.

Shortly after the call the events leading to this review unfolded. GMP CSE team officers updated MPS officers at around 10.45 hours.

4 Learning from the Review

4.1 Learning from the Terms of Reference/Key Lines of Enquiry

1. Did agencies seek opportunities to understand and act on Dina's feelings about her daily lived experience? How did they do this; what was the outcome?

Whilst agencies provided opportunities for Dina to talk about her daily lived experience, it is clear that efforts to engage Dina were largely unsuccessful. Dina's refusal to engage with services, coupled with a lack of professional curiosity about the reasons for Dina's behaviours and what might help her in managing the complexities of her life on a day to day basis, meant that services did not fully understand Dina's wishes and feelings.

Attempts were made to speak to Dina by MSN, teachers, social workers, the Complex Safeguarding Team and counselling service (Keren), however, when Dina showed resistance, these services missed opportunities to find creative ways to engage Dina. Dina's behaviours appear to often have been perceived as Dina being 'difficult' rather than as an outward sign of her internal conflicts and concerns.

Dina minimised risks that were known to agencies (self-harm, CSE, drugs), however, there appears to have been no discussion as to whether this minimisation increased the potential for significant harm, and therefore constituted a rationale for S47 enquiries in relation to statutory intervention.

2. Were agencies aware of issues in relation to suspected child sexual exploitation (CSE), if so what action did they take and what was the outcome?

From July 2018 onwards, following the disclosure made to Keren, agencies involved with Dina were aware of issues in relation to CSE (although at that time the alleged perpetrator, Suspect 1, had not been identified).

When Suspect 1 presented to a police station in London saying that he had been accused of raping Dina, both MPS and GMP became aware of potential issues related to CSE.

At this time MPS were in contact with GMP and with local services who were working with Dina and her family. GMP agreed to MPS investigating incidents that had taken place in the GMP Force area.

It was good practice for MPS to lead the investigation into Suspect 1, however there appears to have been a lack of clarity amongst other agencies in relation to management of

the case as a whole (not only from the criminal perspective). Had there been a clear multi-agency agreement and plan, this would have helped to establish a co-ordinated approach to the case across agencies and geographic boundaries. The review has identified that single and multi-agency working in relation to CSE took place, however there is a lack of clarity about who was leading CSE work from a multi-agency perspective.

Following the strategy meeting in July 2018, the Manchester CSE nurse cross-checked whether Dina was known to the Manchester Complex Safeguarding Team and established that Dina was not known. It would have been useful if the CSE risk indicator checklist had been shared with MSN to use as part of the health assessment.

In summary there does not appear to have been a plan in place that had Dina at its centre. It is clear that Dina did not want to engage with the CSE services offered, although Dina and her parents appear to have had continuing (and frequent) contact with MPS in relation to the pursuance of evidence of criminal activity by Suspect 1.

The lack of a co-ordinated multi-agency plan appears to have had the unintended consequence of compounding parental suspicion of services and leading to an over-reliance on the officer in MPS to co-ordinate and direct local services, which was not his role.

3. Did agencies give consideration to Dina's mental health needs; was mental health screening and referral considered? If not, why was this?

The review has seen reference being made by practitioners in a range of settings to Dina's mental health as an important element of her presentation, however, there is no evidence that any agency considered mental health screening or referring Dina to specialist mental health services.

There were several missed opportunities to undertake mental health screening and make a referral to specialist services, these missed opportunities to assess and refer are apparent in all the services involved with Dina and her family during the period under review. Emotional health and wellbeing should be a core component of work in relation to CSE and work in this area needs to be strengthened.

It is clear to the review that Dina's behaviour was a reflection of her internal distress. What is not clear is whether professionals appropriately recognised this or responded in a consistent way. There were missed opportunities for MSN to lead on advocating and planning in relation to distress via mental health screening. The review believes that this is a fundamental element of the school nurse role.

School 1 and School 2 made reference to counselling and support services (psychological services) being available through 'private' sources. It is not clear how this provision links to the local pathway for child and adolescent mental health services.

There is no evidence that 'private' providers screened or made referrals in relation to Dina's mental health needs. Nor is there evidence that consideration was given to screening or referral following Dina's disclosure to the therapist that she had tried to induce a heart

attack (this appears to have been based on Dina's minimisation of this as a significant event).

The review has concluded that Dina should have received screening and referral for mental health services, and that there were a number of missed opportunities to formally screen and assess Dina's emotional and mental health, with a view to referring her to these services.

4. Were agencies aware of Dina's suicidal ideation? What did they do about this and what was the outcome?

When Dina was first referred to Keren by a family friend, the referral contained information that Dina 'was not suicidal but was bleak about her future.' It is not clear how this information was assessed by the referrer.

From July 2019, when Keren made a referral to CSC, both agencies were aware that Dina had expressed feelings of hopelessness and seeing her future as bleak – although it is not apparent that at this time she had disclosed thoughts of suicide to either agency.

Following Dina's disclosure of suspected CSE in July 2018, information was shared with CSC that Dina had contemplated suicide. There is no indication that this specific risk was explored with Dina or her family. There is no indication of screening of Dina's mental health and whether she had contemplated acting on her thoughts of self-harm/suicide.

The health assessment that took place in November 2018, almost four months after the initial referral. The assessments recorded Dina's thoughts of self-harm and that Dina had acted on these (attempting to take an overdose of cocaine and buying cyanide on the internet). MSN also noted that Dina had spoken of trying to 'slit her wrists'. When Dina said that she had made up that she had used drugs and had thought about self-harm and taking her own life, this appears to have been taken at face value (and only explored 18 days later in safeguarding supervision) with no apparent consideration being given to escalating to CSC based on the presenting risks.

Throughout Dina's involvement with CSC there is no indication that contemplation of suicide and evidence of acts of self-harm were assessed as being a significant risk for Dina by any of the Social Workers involved with her.

Records from CSC and School Nursing refer to parental lack of control and inability to set and maintain boundaries for Dina. However there appears to be no parenting assessment or evidence of consideration of escalation based on potential neglect (in the form of keeping Dina safe from harm).

Resistance to engagement and reassurance from parents that things were improving and that Dina was no longer at risk were taken at face value and led to closure of the case, rather than consideration of escalation. It would have been good practice to undertake a multi-agency review of the case before closure.

5. How did agencies involve Dina's family; was this successful in improving outcomes for Dina? Were there any barriers encountered by agencies in this respect (for example CSE, diversity, resistance to engagement with services by Dina or her family). How did agencies address these barriers?

Agency involvement with Dina's family was variable and inconsistent. Both school 1 and school 2 reported that Dina's parents were engaged with them, and that parents were supportive of Dina in relation to her schoolwork, and to addressing behavioural issues. However, School 2 noted that there were a number of occasions on which they did not feel that parents had been completely open and honest with them. There was recognition that Dina was a strong character who did not respond easily to discipline and constraints being placed on her. This was recognised as being a potential source of conflict in the family relationships.

A family friend mediated when Dina was referred to the Keren service, which appears to have been a helpful introduction to the service. However, it was clearly a challenging move when Keren made a referral to CSC, and this may have served to alienate the family from the service. However, the review considers it was good practice for Keren to make the referral based on the information that Dina had disclosed.

The relationship between the family (particularly mother) and CSC was difficult from the outset. Mother reflected that she was suspicious of the service and that she disagreed with the methods they were using to address CSE issues.

The case was at the level of Child in Need and therefore parental consent and voluntary participation was needed, however, this does not negate the need for further discussion regarding risks and engagement. Dina was not engaging and parents were finding it difficult to safeguard her, this should have stimulated discussion regarding escalation rather than case closure.

Mother also felt that too many social workers had been involved in the case, and she could not see what benefit the family would gain from having services in their lives. Mother said that she decided that she would have to go along with services in the short term, but that she did not intend to maintain contact with them any longer than she felt was absolutely necessary.

There is no doubt that the family felt that CSC and GMP lacked cultural understanding in the context of the orthodox Jewish community, or that they had little understanding of what Dina's life was like and the codes that guided her and her expectations for the future. The family perceived this as a major barrier to working effectively with services, other than with MPS (as referred to elsewhere in this report).

CSC acknowledged in their report to the review that they had not taken action to understand the specific cultural context for Dina, particularly in relation to CSE. This was compounded by the family's suspicion of the service and reticence to engage with CSC. CSC

attempted to undertake a C&F assessment with Dina's siblings, however the family refused this.

The case was closed in November due to Dina's parents reporting that things at home had improved and they did not feel that the family needed involvement from CSC.

The closure of the case by CSC at this time was a missed opportunity to review the case, and to fully consider whether there was sufficient concern about lack of engagement and ongoing risks, that may have warranted escalation to statutory intervention.

From the first contact with MPS, Dina's parents maintained contact with them in relation to the criminal investigation of Suspect 1. A working relationship developed between the parents and one of the investigating officers, within which the parents appear to have relied heavily on the officer to provide updates and advice and act as their primary means of contact with services.

Whilst it is essential that families have professional support in cases such as this, reliance on the MPS officer may have impacted the family's perception of and engagement with other services. This may have had the unintended consequence of weakening the links between parents and local services, and potentially deepening their feelings of suspicion and mistrust about CSC.

It would have been good practice to put in place an agreed local lead professional for Dina and to formulate a multi-agency risk management plan. This would have provided clarity in relation to joint working, both across agencies and geographic boundaries, and in relation to both the criminal investigation and Dina's identified risks and vulnerabilities. It would also have provided a single point of contact for the family which would have enabled them to build a trusting and supportive relationship, rather than numerous contacts with a range of professionals from different agencies.

6. Did agencies take account of equality and diversity (culture, ethnicity, religion) when addressing Dina's needs. What impact did equality and diversity have on agency practice or direct work with Dina?

In large part insufficient account was taken of the impact of Dina's cultural heritage and daily lived experience as a young woman from the Ultra-Orthodox Jewish community. This was particularly the case in relation to some interventions in relation to CSE, which would have been challenging for Dina, despite her suspected (and now confirmed) exposure to sexual exploitation (i.e. materials that might be perceived to 'normalise' the concept of sex before marriage).

The review saw evidence that SW1 worked closely with School 2 and recognised the importance of Dina's culture. However, this did not translate into work that Dina's family could relate to. This therefore served to reinforce parental feelings of a lack of cultural understanding, particularly in relation to CSE interventions.

Clearly School 1, School 2 and Keren were cognisant of the personal and social norms and mores for Dina as a member of an ultra-orthodox Jewish family, and were aware that specific roles and expectations would have been placed on Dina as a young woman in this context. However, there is no evidence that practitioners in CSC, GMP or school nursing, considered the cultural context for Dina when working with her.

7. How did agencies work together, both generally and on specific issues? Are there examples of good practice in relation to interagency working? What lessons can be learnt?

For the most part multi-agency working was uncoordinated and inconsistent. There is no clear sense of leadership in managing the complexities presented by Dina, nor is there clarity regarding which agency was taking responsibility as the lead professional for Dina and her family. In short there was no coherent, cross boundary multi-agency plan that all professionals could work to.

There are records of frequent communication between MPS, GMP, the Complex Safeguarding Team and CSC, however there is a lack of clarity regarding respective roles, relationships and leadership, which appears to have led to agencies working in silos.

Communication between SW1 and School 2 appears to have been good, although again there is no indication of which agency is acting as lead in planning, evaluating outcomes and communicating with other agencies and with Dina's parents.

There is little evidence of multi-agency planning and joint working in relation to Dina's physical and mental health. Nor is there any indication that agencies shared concerns and views in relation to escalation (rather than closure) of the case.

5 Conclusions and Recommendations

Learning from the review has been grouped into themes to enable conclusions to be linked to recommendations. These are set out below under themed headings:

5.1 Self-Harm/Suicide

Whilst there is evidence that services are aware of the risks associated with self-harm and the links to suicide, there is little evidence in this case that professionals appropriately assessed and responded to Dina's suicidal thoughts and behaviours. This is the case across all services, including those outside of the local area.

There is a need to ensure that responses to disclosures of self-harm and suicidal ideation are robust and that all professionals have access to training in relation to signs, what and when to ask, how to refer and how to work together to safeguard young people at risk.

There is also a need to focus on how to work with families where the young person is expressing thoughts of suicide/making attempts at suicide and to make clear and strengthen the offer to parents and families of young people at risk.

Although it was not known prior to Dina's death, it is apparent that she was involved in discussions with other young people about taking their own lives (referred to as a suicide pact). This illustrates the dangers associated with cluster suicides and contagion. There is a need to develop a contagion strategy which recognises contagion as a significant factor in suicidal ideation and behaviour amongst young people.

Recommendation 1

(a) The Board should receive assurance that there is a clear and robust multi-agency strategy relating to young people at risk of suicide, and that professionals are well trained and clear on how to identify and refer young people at risk.

(b) The Board should liaise with Public Health regarding a local Suicide 'Contagion' strategy (guidance for which can be found in the NICE national strategy cited in the main report).

5.2 Child Sexual Exploitation/Complex Safeguarding

The approach to working with victims of CSE, both locally and nationally, needs to be culturally sensitive and take into account specific aspects of equality and diversity.

Where criminal investigations are taking place, the complexities of cross boundary working should not negatively impact work with the victim.

There is a need for absolute clarity regarding who is leading the work with the young person and their family, the primacy of the safeguarding of the young person (in the context of criminal investigation), and a single point of contact for families with a lead professional who has influence and understanding in relation to the young person's needs, the context of their lived experience and how best to engage families. This needs to be expressed in the form of a multi-agency plan which encompasses all aspects of work with the young person and their family.

Recommendation 2

(a) The Board should receive assurance from the Greater Manchester Complex Safeguarding Partnership[15] that culturally appropriate practice and materials (for Orthodox Jewish and other minority communities) are in place, or are being developed.

(b) The Board should be assured that there are robust arrangements in place for cross boundary working in relation to CSE.

5.3 Mental Health

Dina's difficulties in relation to emotional wellbeing and mental health were never formally screened or assessed by any professional. There is a need to ensure that local pathways for mental health screening and referral are embedded in practice, and that the child's mental

[15] https://greatermanchesterscb.proceduresonline.com/chapters/contents.html

health needs are always considered and that appropriate and timely screening and referrals are made.

There is a need to ensure that the child mental health pathway is designed so that the child has a single journey, rather than multiple uncoordinated contacts.

The use of 'private' therapists, counsellors and psychological interventions need to be woven into the local child mental health pathway to ensure that there is no unintended negative impact on children and young people, or barriers to them accessing appropriate services.

Recommendation 3

(a) The Board should receive assurance that practitioners dealing with complex cases conduct appropriate mental health screening and make referrals to child and adolescent mental health services as appropriate

(b) As highlighted in other SCRs, the Board should collaborate with agencies across Greater Manchester to ensure that the pathways for child mental health and complex safeguarding are robust and complementary.

5.4 Voice of the Child/Lived Experience

Many professionals were involved with Dina during the period under review. Four social workers were allocated to the case (this was due to Dina being involved with more than one social work team). Dina had involvement with two schools, counselling services, school nursing services, specialist health services, therapists and police officers. This was in addition to the involvement of family and extended networks.

There is a need to ensure that the child is not overwhelmed by too many professionals/agencies being involved in day to day working. It would be good practice if agencies across the partnership agreed and applied the principal that one trusted person/professional is likely to be able to support and listen to the child to best effect, and to coordinate agency involvement on the child's behalf.

It is clear that, for reasons which were stated by Dina e.g. having friends to talk to, not seeing herself as at risk, not trusting services, disagreeing with her family; and for some reasons that may be unknown to the review, Dina did not want to engage with services as they were presented to her.

It is essential that professionals are able to recognise and respond effectively to resistance, lack of compliance and minimisation by young people.

It is important that professionals are equipped to understand non-verbal communications and behaviours – these are often reflections of internal difficulties that the child may be unable or unwilling to verbalise.

It is essential that professionals understand and relate to the context within which the child is living, including the cultural context.

Recommendation 4

The Board should receive assurance that agencies are focused on listening to and acting on the daily lived experience of the child in day to day practice. **Links to Recommendation 12 of the 'Daniel' SCR**

Recommendation 5

The Board should receive assurance that agency practice in relation to compliance and consent[16] is robust and enables practitioners to overcome potential barriers to engagement by vulnerable young people and their families.

5.5 School Transfers and Information Sharing

Neither school 1 or 2 notified the Local Authority regarding the transfer of Dina (and her sibling) in January 2018.

Information sharing between schools in relation to the transfer of pupils should comply with national guidance to ensure that transitions are well-managed and all relevant information passes smoothly from one school to another.

Recommendation 6

(a) The Board should receive assurance that policy and practice in schools, in relation to school transfers is consistent and in line with national guidance.

(b) The Board should urge a consistent approach across Greater Manchester with collaborative arrangements being in place with Salford and Manchester (as a number of schools cross these borders).

5.6 Equality, Diversity, Cultural Competence and Culturally Sensitive Practice

Learning from this review and other recent reviews in the local area highlight a pressing need to strengthen relationships between statutory agencies and the local Orthodox Jewish communities (the review recognises that there is more than one Orthodox community in the local area).

There is a need to build bridges between statutory and third sector agencies and the ultra-Orthodox Jewish community. Perceptions on the part of the community regarding mainstream services, coupled with a lack of trust and a tendency to insularity, may lead to a breakdown in communication and relationships, which could place vulnerable young people at greater risk of exploitation, drug use and unresolved mental health issues.

Agencies reported to the review that work is ongoing to strengthen relationships with the ultra-Orthodox Jewish community, however, this review has highlighted that more needs to be done to achieve strong and effective joint working.

[16] https://www.workingtogetheronline.co.uk/chapters/chapter_one.html

Strong and clear leadership within the Orthodox Jewish Community is needed to ensure that the lessons learned from this and other recent reviews can be converted into actions that strengthen safeguarding and reduce risks to young people.

There appears to be a preference in the ultra-Orthodox Jewish community to using 'private' services from within the community itself. The element of choice must be respected, however, there is a need to ensure that this does not alienate young people or reduce their visibility to mainstream services, particularly when there are safeguarding concerns identified. There is a need to ensure that interventions taking place outside of mainstream services are linked into local pathways for a range of services and that such services are compliant with Section 11 of the Children Act.

Some contributors to the review observed that families in the Haredi community are large, and that parents may have their first child at a young age. It was highlighted that this can place a strain on parenting and that many young Haredi parents may not have the skills to manage the challenges of modern life (particularly the influences of social media), having themselves grown up in insular families and communities. Parenting support, assessment and interventions need to take into account specific cultural influences when being formulated and delivered.

Cultural awareness, understanding and practice in relation to working with young people and their families from the ultra-Orthodox Jewish community needs to be strengthened. This can only be achieved by joint working and shared purpose by local leaders and the statutory agencies.

There is a need to review materials used and develop a culturally appropriate suite of tools for direct work with young women from the ultra-Orthodox Jewish community, particularly in relation to sexual exploitation and vulnerability, as current materials may present barriers to engagement for young people and their families.

Recommendation 7

(a) The Board should use the findings from this review to further inform ongoing work in the Borough designed to strengthen relationships between commissioners of both statutory and non-statutory services and the local Orthodox Jewish Community to ensure that children within that community are safeguarded. **Links to Recommendation 1 of the 'Daniel' SCR.**

(b) The Board should receive assurance from the Manchester Beth Din[17] that it is satisfied that, where appropriate, non-statutory services provided to the local Jewish community are fully compliant with Section 11 of the Children Act (1989).[18] **Links to Recommendation 12 of the 'Mario' SCR**

NB References and footnotes are included throughout the report.

[17] http://www.mbd.org.uk/site/page/beth-din
[18] https://www.manchestersafeguardingboards.co.uk/resource/section-11-audits-information-practitioners/