Bury Integrated Safeguarding Partnership

7 Minute Briefing: Dina

Bury Integrated Safeguarding Partnership produces 7 minute briefings on various current safeguarding issues and learning from reviews. They are intended to be simple so that the reader can absorb the information easily and teams can use them within meetings as a team based learning exercise.

They are based on a technique developed from the FBI. The content of the briefings will be a mixture of new information or a reminder/repeat of basic information which can help teams think about the application to practice.

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1. Background

Dina was the second oldest in a family of six siblings. Dina lived with her parents and siblings, in the family home. The family are members of the Haredi Jewish Community. This Serious Case Review (SCR) was commissioned by Bury Safeguarding Children Board (now Bury Integrated Safeguarding Partnership, BISP) as indications are that Dina appears to have taken her own life in January 2019. At the time of her death, Dina was 16 years old.

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2. Safeguarding Concern

In the 18 months prior to her death, Dina experienced difficulties with her emotional health and wellbeing. Dina's parents moved Dina to a new school as they felt that she may benefit from a changed environment and a fresh start. Dina's behavioural issues appeared to deepen and her parents' concerns about her increased. It is clear that Dina had begun to test boundaries with her parents and in school and social settings.

Dina was referred to a counselling service who work with young people from the Orthodox Jewish Community. Dina disclosed to a therapist that she had been 'seeing an older man' in London. She said that she had had sex with him. She also disclosed that she had taken drugs. A safeguarding referral was made to Children's Social Care (CSC). Dina disclosed suicidal thoughts to her family and a number of professionals. She also disclosed self-harm to a private therapist.

Following a period of sporadic contact with CSC, during which Dina was classed as a Child In Need, CSC closed the case as Dina did not want to engage and her family reported that things had begun to improve. Dina was advised that she would remain 'open' to the Complex Safeguarding social worker as a police investigation into possible Child Sexual Exploitation (CSE) was ongoing.

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3. Incident

Dina's father told police that on the morning of Dina's death he had seen her early in the morning when she had said that she was going out to the gym. Dina's mother became concerned as Dina had not arrived at school. Dina's father decided to look for Dina at a derelict house that was owned by a family member, he found Dina's body there. Police and Ambulance services were called to the scene, where it was confirmed that Dina had died.

Police found pictures of a 'suicide note' on Dina's phone. The note 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 the 'older man' (the man she had previously disclosed that she had been seeing in London). The cause of Dina's death will be determined at a Coroner's Inquest in November 2019.

4. Findings

- There is little evidence that professionals appropriately assessed and responded to Dina's suicidal thoughts and behaviours.
- There is a need to develop a contagion strategy which recognises contagion as a significant factor in suicidal ideation and behaviour amongst young people.
- The approach to working with victims of CSE needs to be culturally sensitive and there is a need for clarity regarding who is leading the work with the young person and their family.
- There is a need to ensure that local pathways for mental health screening and referral are embedded in practice and that appropriate and timely screening and referrals are made.
- It would be good practice if agencies applied the principal that one trusted professional is likely to be able to support and listen to the child and to coordinate agency involvement on the child's behalf.
- It is essential that professionals are able to recognise and respond effectively to resistance, lack of compliance and minimisation by young people.
- Strong and clear leadership within the Orthodox Jewish Community is needed to ensure that the lessons learned can be converted into actions that strengthen safeguarding and reduce risks.
- There appears to be a preference in the ultra-Orthodox Jewish community to use '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.

5. Recommendations: Key Areas

- BISP should receive assurance that there is a robust multi-agency strategy relating to young people at risk of suicide, and that professionals are clear on how to identify and refer young people at risk.
- BISP should liaise with Public Health regarding a local Suicide 'Contagion' strategy.
- BISP should receive assurance from the Greater Manchester Complex Safeguarding Partnership that culturally appropriate practice and materials are in place.
- BISP should be assured that there are robust arrangements in place for cross boundary working in relation to CSE.
- BISP should receive assurance that practitioners dealing with complex cases conduct appropriate mental health screening and make referrals to mental health services as appropriate.
- BISP should collaborate with agencies across Greater Manchester to ensure that the pathways for child mental health and complex safeguarding are robust and complementary.
- BISP 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.
- BISP should receive assurance that agency practice in relation to compliance is robust and enables practitioners to overcome barriers to engagement by young people and their families.
- BISP should receive assurance that policy and practice in schools, in relation to the transfer of pupils, is consistent with national guidance. BISP should urge a consistent approach across Greater Manchester with collaborative arrangements being in place with Salford and Manchester.
- This review should be used to further inform work designed to strengthen relationships between commissioners of services and the Orthodox Jewish Community
- BISP should receive assurance from the Beth Din that it is satisfied that non-statutory services provided to the Jewish community are compliant with the Children Act (1989).

6. What to do

- Make yourself familiar with suicide antecedents and the suicide prevention strategy.
- Visit Public Health England who provide tools to help professionals https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance
- PAPYRUS UK provides advice concerning suicide prevention: 0800 068 4141.
- The learning from this SCR should be used to ensure practitioners consider a young person's mental health needs, recognise and respond effectively to lack of compliance and minimisation by young people and understand the context within which the young person is living, including the cultural context.

7. Questions to consider

- Consider if you are familiar with up to date research about suicide.
- Use this Review to engage staff in discussion and learning about teenage suicide.
- Reflect on the findings and discuss the implications for your service/practice/school.