Statement from Professor Michael Preston-Shoot
Independent Chair, Luton Safeguarding Adults Board

The Luton Safeguarding Adults Board has today (Thursday 7 July) published the Executive Summary of its Serious Case Review into the murder of Adult A (Michael Gilbert).

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Independent Chair, Luton Safeguarding Adults Board.

Introduction

In May 2009 Adult A was found murdered. At the trial in 2010 Adult B, Adult B's partner and another woman were convicted of murder and given prison sentences. Three others were convicted of causing or allowing the death of a vulnerable adult.

All members of the Luton Safeguarding Adults Board were appalled by the circumstances in which Adult A was forced to live for periods of his adult life and by the manner of his death. All members of the Board extend their sympathies and condolences to surviving members of Adult A's family.

Background

Luton Safeguarding Adults Board comprises all those statutory agencies which commission and/or provide services for adults at risk. It works closely with other providers of services, especially concerning the provision of residential, nursing and domiciliary care. As part of ensuring effective oversight of the policies, procedures and practices relating to the prevention and protection of adults from significant harm, the Board has appointed an independent chair and publishes an annual report.

When adults die as a consequence of abuse, or experience significant harm, the Board will normally commission a Serious Case Review, or similar form of investigation, and publish an executive summary of its findings and conclusions. The purpose of a Serious Case Review is not to apportion blame but rather to identify points of learning which should inform subsequent good practice.

Terms of Reference

Specific terms of reference were set for this Serious Case Review. Agencies known to have worked with Adult A were asked to inquire into their involvement, with specific reference to the period between when he was in care at the age of fifteen and his death. Specific attention was to be paid also to information sharing, to how individual agencies worked with Adult A and with each other, and to whether there was any evidence to suggest that Adult A was a vulnerable person as defined by legislation.

The purpose of the Serious Case Review was not to investigate the family circumstances, or the services that were or might have been provided to those who held Adult A captive and from whom he experienced extravagant cruelty. Nor was the purpose to inquire into his early childhood and the supports that were offered to his family at that stage. However, to make sense of some of the events later in his life, namely his late adolescence and early adulthood, it was necessary to acquire some understanding of his infancy and early childhood.

The Serious Case Review, and the executive summary which has been published today, draw together the details from separate investigations conducted by individual agencies involved with Adult A. The executive summary is intended as a learning tool for agencies in Luton and nationally since, sadly, the horrific events featured in this case are not unique.

Key Findings

Adult A's life between 1982, when he was born, and 1998 was marked by degrees of emotional turmoil, some of which laid the foundations for his later mistreatment by those ultimately convicted of his murder. Accusations of sexual assaults, sexual and physical bullying, pubertal changes and instances of parental rejection, are noteworthy in this respect. Practice relating to children in need and children requiring protection has evolved significantly since this time, both nationally and in Luton, driven by major legislative change (Children Act 2004; Children (Leaving Care) Act 2000) which has set higher standards for inter-agency working, support for care leavers, management of those convicted of sexual and/or violent crime, and intervention to enable positive outcomes for children. Judged by these more recent standards, professional intervention when Adult A was a child and young person could have been more focused, in an attempt to safeguard and promote his welfare. However, it would not have been possible for those agencies involved with him then to have predicted the potential future significance of the events that marked his early years.

The period from 1999 to his death is marked by periodic requests for support and agency involvement, but also by rejection of assistance offered. His attitudes towards his association with Adult B and his family similarly fluctuated. Professional intervention may have accorded with practices current at the time but it was largely reactive and insufficiently questioning. Once again there has been legislative change (Crime and Disorder Act 1998; Anti-Social Behaviour Act 2003; Mental Capacity Act 2005) which has set new guidelines and practice standards for work with young offenders and for those whose decision-making capacity may be in doubt.

The executive summary refers to the absence of a single co-ordinating agency and the managerial separation of agencies. Children Act 2004 has sought to remedy that absence nationally by requiring agencies with responsibilities for children and young people to co-operate. This co-operation is audited, promoted, monitored and evaluated by Local Safeguarding Children Boards. Whilst not yet governed by statute, similar oversight functions are carried by Local Safeguarding Adult Boards.

Across adult services there is currently no statutory duty to co-operate or to share information. Several police forces were involved periodically with Adult A but systems for sharing information at that time were less developed than now. Computer systems and information-sharing protocols have been implemented, designed to address such features as those in this case (recommendation 7). Similarly, the challenges involved in dealing with cases where there are high levels of anti-social and challenging behaviour require that agencies share information and responsibility for determining how best to intervene (recommendation 2). As part of recommendation 8, Luton Safeguarding Adults Board will require local agencies to create a forum, akin to MAPPA, to discuss such cases involving adults at risk.

Adult A was not a disabled person within the meaning of current child care or adult social care law. Therefore, there was no requirement for his automatic referral as a young person by children's services to adult social care. Nor would he have necessarily met the eligibility criteria determined against statutory guidance had he been referred at any time to adult social care. However, modern day practice would require that, at the point of transition of leaving care, and because of the vulnerabilities which he experienced, consideration be given by both children's services and adult social care to meeting his future needs. Luton Safeguarding Adults Board will work closely with Luton Safeguarding Children Board to ensure that the systems now in place are effective in considering how to meet the present and future needs of young people who may be vulnerable and who are approaching adulthood (recommendations 4 and 6).

The Mental Capacity Act 2005 enshrines in law the right of competent adults to take decisions, even unwise ones. Being competent to take decisions requires that an adult can understand information about the decision to be made, retain that information and use it as part of the decision-making process, and communicate a decision. Less explicit in the guidance which accompanies the Act is what might be termed "executive capacity", the ability to implement decisions taken and to deal with the consequences, and the impact of someone else's undue influence on the decision-making process. Arguably, on some occasions, Adult A might not have had decision-making capacity either because of the undue influence of Adult B and his family or because of his own inability to implement a decision to separate from his captors. Hence the executive summary (recommendation 8) advises that Luton Safeguarding Adults Board refer the circumstances of this case to the Law Commission, which has made recommendations for the reform of adult social care law to government.

Equally, it is clear that professional assessments of Adult A's decision-making capacity were insufficiently rigorous. The right to self-determination and autonomy should be safeguarded but in this case there were clear indications of coercive behaviour towards Adult A by Adult B and associates, which should have led to questioning of whether Adult A had decision-making capacity (recommendation 3).

If some professionals on some occasions had assessed in more detail Adult A's decision-making capacity, they might also have considered his vulnerability and the different

positions that Adult A himself took – sometimes asserting his vulnerability in relation to Adult B and his associates, and sometimes presenting himself as not vulnerable. Such detailed questioning and assessment might have led to the conclusion that Adult A was being abused or neglected within the meaning of Department of Health statutory guidance to protect vulnerable adults. However, no referral was received by adult social care or adult protection services (recommendations 1 and 3).

Luton Safeguarding Adults Board accepts in full the recommendations listed in the executive summary and will document through its annual reports the progress made with their implementation. Following due legal process, individuals have been convicted of offences against Adult A, including murder. The learning identified through the serious case review process reminds all agencies of the importance of supporting professionals as they attempt to intervene in cases involving violence and anti-social behaviour, of sharing information about young people and adults at risk, and of critically reflecting with individuals themselves about the vulnerable positions in which they find themselves.