Luton Safeguarding Vulnerable Adults Board

The Murder of Adult A (Michael Gilbert)

A Serious Case Review

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Introduction

In May 2009, the headless, dismembered body of 26 year old Adult A was found in the Blue Lagoon at Arlesey in Bedfordshire. He had been murdered four months earlier by Adult B, Adult B's partner and another woman. At the trial in 2010, it emerged that Adult A met Adult B at a children's home where they were residents. Adult A became part of Adult B's family whose extravagant cruelty included inflicting intense physical pain and keeping Adult A captive in order to fraudulently claim his benefits. A further three people were convicted of *causing or allowing the death of a vulnerable adult.* In 1997, Adult A was 15 and 'in care.' He remained under the guidance of the Luton Leaving Care Team until his 21st birthday. At the time of his death Adult A was not deemed to be eligible for Adult Social Care services.

About this Serious Case Review (SCR)

The SCR was commissioned by Luton Safeguarding Vulnerable Adults Board and is based on information from: Assessment and care Management, Adult Social Care, Luton Borough Council; Bedfordshire Probation Trust; Bedfordshire Police; Cambridgeshire County Council; Cambridgeshire Police; Children and Learning (the integrated Children and Young People's service); Department for Work and Pensions; English Churches Housing Group; Housing/ Landlord Services, Luton Borough Council; Lancashire Police; NHS Luton; Norfolk Constabulary; Norfolk County Council; and the Department of Work and Pensions.

The Scope of the SCR

The Terms of Reference focused mainly on Adult A's life after 15; on his contacts with the convicted perpetrators (Adult B, his family and partner); and on Adult A's decision-making capacity. Also, agencies were asked to consider their definitions of "vulnerability" and the implications for Adult A; and to reflect on their working with other agencies and their information-sharing.

To make sense of events in Adult A's late adolescence and early adulthood the following section outlines something of Adult A's infancy and early childhood.

Adult A's early life

Adult A was born in 1982, the third of five children. His family was not a haven of stability. All but his youngest sibling were in care at different stages of their early lives. Adult A's early years were characterised by periods of trauma, turmoil and strained finances. The children were raised in an intermittently single parent household in which Adult A was perceived as "the favourite." It is not known whether or not (i) his siblings moved between households, (ii) new partners were accepting of the children of previous partners, (iii) the children became estranged from the men who left the family, (iv) there were rifts and reconciliations as a single parent family became a two parent family. An inconclusive investigation of alleged

sexual abuse by Adult A in 1993 vitally influenced subsequent events in his life, shaping for example, how he was perceived and dealt with. Similarly, the bullying which Adult A endured at school may have been regarded as difficult to suppress. Further, pubertal changes, which are highly variable, were particularly distressing for Adult A, who underwent a mastectomy at 13.

Between 1983 and 1996, Adult A had four addresses in Luton, including those of foster carers.

Glimpses of Adult B's life are presented in tables in *italic*.

In 1996,	*Adult B (who was 13) was interviewed concerning an indecent assault on an infant.*

Adult A's life 1997 - 2008

During **1997**, Adult A's mother informed the police of her son's sexual assault of a boy, perhaps indicating a change to his previously exalted and protected position of *favourite.* The allegation resulted in removal from the family home and Adult A's misrepresentation of the impetus for this. Although assaulting his sister may have appeared to Adult A less reprehensible than assaulting a boy, sexual bullying, name calling and physical bullying followed.

During 1997, Adult A had moved between a children's home and foster carers in Luton.

In 1997,	*Adult B (who was 14) assaulted his uncle who was disabled.*

By **1998**, Adult A no longer lived with his family. He was accused of sexually abusing a young boy, and he met Adult B in a children's home. Adult A's participated in street crime which was undertaken with peers, all of whom were absconding. The circumstances which brought Adult A into the children's home had antecedents in his sister's allegation of sexual assault in 1993, and his rejection by his mother. On an occasion that he absconded, alone, he was missing for a week.

During 1998, Adult A had four moves between two children's homes and foster carers.

In 1998,	*Adult B (who was 15) was reported as firing a pellet gun at passers-by. He was placed in care for threatening his mother with a knife. He was convicted for shoplifting.*

In **1999**, and within a two year time frame, Adult A acquired 10 convictions/ cautions, largely for burglary, criminal damage and shoplifting, and was regarded as a danger to young children. It is not known whether or not he received the assistance he requested in *keeping away from Adult B.* Critical times during this timeframe include the shift from being bullied and bullying others, to becoming a victim of bullying only; his withdrawal from school; limited contact with his family; emerging bonds *with people who would not benefit him long term…*(for example) *known prostitutes* (it appears unlikely that Adult A had the knowledge and skills to engage in safe sexual activity); the loss of routines such as sleeping at night; generalised non co-operation; and restlessness.

During 1999, 16 year old Adult A had six moves between two children's homes, a hostel and a night shelter for homeless people.

The year **2000** witnessed, inter alia, Adult A's avoidance of the police (he believed that they would *not do anything*); his rejection of assistance for injuries; and difficulties with money management (he had rent arrears). Although Adult A's support needs were urgent and complex, the professional interventions he experienced were unpromising in terms of nurturing his entrance into responsible adulthood. He was sentenced to a Young Offenders' Institution and his subsequent transfer to a hostel occasioned bullying. He was perceived as *immature…easy to manipulate,* not least because of his continued association with peers who were persistent offenders.

During 2000, Adult A moved between a prison, a Young Offenders Institute and two hostels.

In 2000,	*Neighbours reported Adult B to the police. He had injured a child with an air weapon. An in-law reported Adult B to the police because of his violence within the family home.*

In **2001**, Adult A did not honour appointments and his enthusiasm for attending courses and securing accommodation was short lived. The expectations of services at that time appear punitive and extraordinarily demanding. His sister's relationship with Adult B and her reception into their family home were critical events insofar as they drew Adult A further into Adult B's family life where he was, *inter alia,* subject to sexual name calling/ bullying. His claim that he had *got a girl pregnant* suggests that he was not participating in safe sex.

Adult A's nomadic life in extremely deprived environments centred on Luton. During 2001, Adult A moved between seven Luton addresses, including a night shelter.

In 2001,	*Adult B was arrested and bailed for assault and he ignored the bail conditions. Adult B and Adult A's sister applied for housing. By 2001, there had been 112 incidents involving the police visiting Adult B's family*

	home. Thirty-five of these occurred in this year.

In **2002**, the police were informed by Adult A and his mother that Adult A had been kidnapped by Family B. On two occasions Adult A's mother had previously reported that her son had been assaulted by Adult B. It is not known whether Adult A's repeated gravitation towards Adult B's home was because he wanted to be with his sister, who was living there with Adult B, or because he wanted to be part of Adult B's family. It is significant that when Adult A told his mother about the abduction and assault and his fear of Adult B and his family he was *too scared to report it to the police*. It is unclear whether this was because Adult A was scared of the police and/ or the consequences for him and his family. Adult A's wish to be accompanied by his mother, as an appropriate adult, suggests apprehension on Adult A's part. This was permitted.

Although kidnapping and falsely imprisoning adults are rare offences, there is evidence that such offenders are more likely to be convicted of further kidnapping and that they are very dangerous in terms of offending escalation (Liu *et al* 2007). Adult A's family's representations to the police accurately foreshadow Adult A's circumstances at the time of his torture and murder seven years later. It is possible that negative judgements as to the truthfulness of Adult A and his family in their person to person encounters with the police played a part in their decision to discontinue enquiries. It is now known that (i) information about another man, of the same name, who lived in another part of England, was responsible for, inter alia, *false allegations of assault,* resulting in Adult A being erroneously perceived as responsible for the other man's crimes; (ii) misinformation regarding the dates of treatment for injuries; and (iii) information from Adult A's social worker, converged to question the veracity of the allegations and shaped police decision-making. (Bedfordshire Police acknowledge that they had failed to adequately respond to, investigate, document and supervise their investigation of Adult A's allegations.)

Arguably in a bid to break from Adult B and his family, Adult A left Luton for Norfolk. During 2002, Adult A moved between five addresses in Luton and Norfolk.

In 2002,	*Adult B was arrested and charged with possessing an air gun with intent to cause fear of violence. Within two weeks his brother was arrested for the same crime. They had been shooting from a vehicle. (Between 2000-2002, the police received five reports of air weapon misuse by Adult B's family); Adult B was sentenced to 18 months in a Young Offenders Institute and his family were evicted.*

Having received no convictions in **2001** and **2002**, in **2003** Adult A became visible to the Criminal Justice System. His assault on a man for *'touching up' girls* suggests that Adult A accepted that it was legitimate for sexual activities to be 'policed' by peers, possibly because

this was his own experience. Adult A again disclosed to Criminal Justice System professionals that he had been beaten up by Adult B and his family. He asked if he might leave the Probation Service's office by a back door to avoid being assaulted. This echoed a request he had made to a social worker in 2001. At this point a referral for enrolment was made by a social worker to a college, reflecting confidence in Adult A's educational abilities. He did not take this opportunity. Adult A was reported as missing but subsequently turned up. The fact that Adult A disclosed to his probation officer that he was *afraid to live on his own,* provides a compelling explanation for his continued association with Adult B and his family.

During 2003, Adult A moved between four addresses in Luton and two in Norfolk.

In 2003,	*Adult B's family left their tenancy following on-going complaints by neighbours. Adult B had non-consensual sex with a girl who sustained injuries but refused to make statement. Later, Adult B was arrested for harassing her. Adult B's sibling reported Adult B to the police for assault and injury.*

During **2004,** Adult A, aged 22, sought assistance from Primary Health Care for *anxiety* and he disclosed *flashbacks* to both physical and sexual assaults by *his sister's boyfriend.* He declined to see a counsellor. Adult A resided with a Registered Sex Offender. He was arrested for *failing to answer police bail,* and later for being in a vehicle taken without consent. Although Adult A was not diagnosed with depression, it is acknowledged that such a diagnosis may have been appropriate. Depression would not have been surprising given the cumulative losses in his life. He misrepresented his living circumstances to the GP by saying that he lived with his girlfriend.

During 2004, Adult A moved between two addresses in Luton, three in Norfolk and there were at least three weeks when he had *no fixed address*.

In 2004,	*Adult B was imprisoned for harassment. Later, his sibling reported him to the police because of his violence. Towards the end of the year, Adult B assaulted and injured his girlfriend's child.*

Although Adult A was barely visible to services in **2005**, he was charged for the theft of a pedal cycle with one of Adult B's brothers. A warrant was issued for his arrest at the end of the year.

During 2005, Adult A moved between three addresses in Luton.

In 2005,	*Adult B was awaiting sentence for assaulting a police officer. His family*

	were evicted and his child was placed in care at birth.

By **2006**, Adult A identified himself as a member of Adult B's family. The prevailing pattern of this association paralleled that of previous years i.e. it peaked in intensity when Adult A joined Adult B and his relatives in criminal activity and then fell off sharply when Adult A escaped from violence. They were arrested on suspicion of theft. Records note that Adult A was living with an unnamed family. He *said he had known this family for approximately 12 years and they 'took him in' after he began experiencing personal difficulties in his own family…*[he] *has been living with this family for approximately 8 months and he thinks of his friend's mother as his own mother and feels very supported by this family.* Adult A was imprisoned for breaching a suspended sentence. After his release, a man reported to the police that his daughter, Adult A's girlfriend, had been threatened by *members of* Adult B's *family. They wanted to know where Adult A was staying and said that if she did not tell them, they would 'kick the hell out of her.'* She *said that Adult A had claimed he had been a victim of assault from* Adult B's *family.*

Although Adult A's role is not known, he was believed to be a witness to Adult B's "befriending" of a young girl. The police were not informed when Adult A was abducted from outside a police station. The police wrote to Adult B concerning his alleged assaults, to which he did not respond.

During 2006, Adult A moved between four Luton addresses, an address in Bedford, prison, and for a period, was of no fixed abode.

In 2006,	*Adult B's family were evicted. He assaulted his sibling. A welfare worker visited Adult B's family home. Adult B's brother spat at her and threw liquid over her. Later, Adult B was arrested for allegedly having sex with a young girl.*

At the beginning of **2007**, Adult A *was named with Adult B as a suspect in a burglary. He told the police that he was rough sleeping in Cambridge.* It might have been significant that Adult A *told his GP that his girlfriend and child were killed by a drunk driver in 2001, "Never been the same since…He was a hyperactive child* whose *family disowned him…would like to see a psychiatrist. (Hears voices when depressed and they accuse him of being ugly…Not been on antidepressants but had diazepam for anxiety.)"*

Adult A gave a sanitised version of his autobiography to a nurse in Luton. He disclosed that he had moved from Bedford and had a family in Luton *but left home at 14 to live in a children's home.* Adult A's homelessness exposed him to new risks of violence as he sought precarious sustenance from drugs and alcohol. A Homeless Shelter's risk assessment of Adult A stated that he was *low risk in all areas except vulnerability which identified him as*

fleeing violence in Luton. Adult A was fined for the theft of wine; he received a Notice to Quit from the Homeless Shelter and was evicted because of arrears and disruptive behaviour.

Subsequently, the man with whom Adult A had been evicted told Cambridgeshire Police that Adult A had been abducted and that, *"*he *looked worried for his life and as if he was going to cry."* He added that *Adult A had moved to Cambridge because he was getting death threats in Luton.* The police *did not consider that there was any evidence of an offence.* Five days later, the police had independent verification that there were concerns for Adult A's safety and began a *missing persons report.*

Separately, they had received a request from Bedfordshire police, "*asking for Adult A to be arrested on suspicion of rape."* Adult A's mother was interviewed. She said that she had not seen her son for about six months and noted that *"he had previously gone nine months without contact."*

Adult A was arrested in Luton some days later. He was with Adult B. There were conflicting views about whether or not Adult A required an appropriate adult. It was noted that he admitted to *smoking cannabis heavily over the last 10 years.* A doctor *confirmed that an appropriate adult should be provided.* A*fter the allegation of rape had been dealt with* and the appropriate adult had left, Adult A was asked about the abduction and he confirmed that he had been *abducted against his will by Adult B, Adult B's girlfriend* and another woman. *He had been driven back to Luton where he had been assaulted.* The notes stated "*I do not wish to make a complaint against these people for any of the offences I have talked about because it will only make it worse for me in the long run. I just wish to return to Cambridge without fear of them following. I do not wish anymore to do with them…I will not support a police prosecution and will refuse to attend court."* Since Adult B, his girlfriend and others were *outside the police station waiting for Adult A,* he was transported to the railway station to avoid them. He left Cambridge in the middle of the year.

This was the second occasion on which Adult A was deemed to require an appropriate adult, as an adult. It is also the third occasion on which Adult A sought the assistance of a professional to avoid the risk of violence. The action of the police in taking Adult A to the railway station could only have short-lived effectiveness.

Adult A had some insight into the poor health outcomes associated with homelessness and substance misuse. In addition to impaired judgement, including an ability to safely negotiate sexual activity, Adult A told a GP that he had been *hearing voices*. He asked for psychiatric help. The police acknowledge that the five day delay in instigating their investigation, *may have contributed to Adult A's vulnerability.*

During 2007, Adult A moved between Bedford, Luton, Lancashire, six addresses in Cambridge and was for a period had no fixed abode.

In early 2007,	*Adult B's family were evicted.*

In **2008**, Adult A was abducted from Lancashire by Adult B. Adult A's girlfriend reported this to the police. Given that Adult A got into the car without the threat of physical duress, it was believed that he had *gone* of *his own accord.* Adult A's Giros were sent to Adult B's address. The tenacity with which Adult B tracked down Adult A is remarkable. It is now known that Adult A was *assaulted and tortured* on a daily basis*…and* (that) *the means of hurting him became more extreme.* Adult B subjected Adult A to torture that neither he nor other participants and witnesses would have wanted to suffer. None of them felt the impact of their roles and actions strongly enough to stop.

During 2008, Adult A moved between Lancashire and Luton.

In 2008,	*Adult B was sentenced to 12 months imprisonment for affray. He was released six months later.*

In early **2009** Adult A (age 26) went to the Job Centre on two occasions. On the second occasion, a Clerk noted that he was injured and advised him to seek medical help. Adult A was last sighted by an associate of Adult B's family some days later. It has been established that Adult A was murdered soon afterwards.

In 2009,	*Adult B's family were evicted.*

Adult A's body was found in **May 2009**. **Adult B**, his girlfriend and the girlfriend of **Adult B**'s brother were convicted of murder. **Adult B**'s brother and mother were convicted of Familial Homicide. All were convicted of perverting the course of justice.

Analysis

The number of disruptive, developmental stresses in Adult A's early life was extensive:

- he lived in an unsafe and fluctuating household which periodically included men associated with child sexual abuse, pornography and violence;
- he was bereft when his status as the *favourite* child was transferred to a sibling when he became estranged from his family on admission into a children's home;
- he was not taken into care soon enough, given the *multiple injuries concerns… physical abuse, sexual abuse and neglect…*(not even when, at 10 months old, a neighbour reported that *he had been physically abused)*;
- he did not receive the medical attention merited by his childhood injuries;

- his relationship with his sister was conflicted after she alleged (as an 8 year old) that he had sexually assaulted her;
- he had a mastectomy;
- his experience of residential care and foster care suggests that there was considerable uncertainty about what to do with him and how to address his bullying, his potentially exploitative sexualised behaviour towards young children, his victimisation, his absconding and his criminal activities. Ultimately, the "solution" was to steer him into other placements;
- as a teenager, he was both a victim and a bully in school and hostels for homeless people. Absconding and immersion in petty crime came to characterise Adult A's experience of residential care. It appeared that the resources of various agencies were strained to the utmost as the pattern of steering him to other placements continued.

There was no evidence of support for the family. Restoring Adult A to his family ceased to be an option when his mother stated that she did not want to care for him. However, it is clear that she continued to care about him. Schools did not feature in any consideration of Adult A's needs. His early life raises questions about the function of Luton's Child Protection Register. In children's social work, residential care, foster care and leaving care service records, there is no reference to care planning, leaving care plans or transition planning. As far as is known, the duties and powers of s.24 of the Children Act 1989, concerning advising and befriending were not referred to. It is unclear when and why the Leaving Care Team ceased involvement or even what expectations they had for Adult A in 1996-2003. Published work refers to endemic weaknesses in the support of care leavers (see, for example, Brammer, 2007; Braye and Preston-Shoot, 1997; Williams, 1995)

As a child and teenager, aspects of Adult A's behaviour were sexualised. Given his early life and history of abuse, it does not appear that there was any attempt to show Adult A non-sexualised ways of seeking and offering affection. Throughout Adult A's life he was plagued by the allegation that he had sexually assaulted his sister. This did not receive the attention it merited. Adult A learned to modify his "cover story," without professional assistance, and to sanitise and/ or deny it (see, for example, Macaskill, 1991) at the same time as he was trying to deal with separation from his birth family and then from his foster family. Adult A's defiant behaviour does not appear to have been seen as a trigger to act by other professionals outwith residential services, but they inadvertently replicated his early life experience in not ensuring his safety. The options for Adult A seemed to have been to become sad, bad or mad – and they got him nowhere. There was no clarity about intervention, about care management or about the appropriate division of responsibility. Although Adult A's experience of residential and leaving care services included contact with mental health and youth justice services, Adult A did not benefit from this.

The years 2003-2009, were a disaster once agencies ceased to have any responsibility for Adult A. The absence of a single co-ordinating agency with oversight of the role/coordination of criminal justice agencies, health agencies, housing, and DWP is stark. The managerial separation of these agencies must be acknowledged. Each had their own resources,

priorities and procedures and was only attentive to time-limited and circumscribed elements of Adult A's circumstances. Although inter-agency work is implied by the provisions of the Children Act 1989, there was no evidence of this during Adult A's teenage years and young adulthood. The integrated Children and Learning service was created in April 2005. Although Adult A was not known to this service, there are gaps in the recording of decisions and their rationale by its predecessor organisation. Adult A did not benefit from "corporate parenting." S.24 of the Children Act 1989 introduced a duty to advise, assist and befriend looked after children between the ages of 16-21. Although the Children (Leaving Care) Act 2000 extended some of the provisions of the Children Act 1989, their implementation was too late for Adult A. As Stein and Carey (1989) observed at this time:

"A group of young people regarded as being in need of care and control up to the age of 16, 17 and 18, are catapulted into a position of greater vulnerability than that of other people their age."

It matters decisively that the social services, the NHS and the police did not meet to clear and negotiate an enduring *child protection* path. However, if the fragmentary information about Adult A's nomadic *adult* life is viewed as a sequence of intermittent, occasionally unfocused and/ or partial snapshots taken by each agency, their limited interventions become more comprehensible.

The evidence endorses the case for inter-agency working. Information gathered from each of the agencies involved illustrates how each agency had an incomplete picture Adult A during the 26 years of his life. There was an array of professionals to whom Adult A and his family were known, and the fact that there were 31 police professionals involved with Adult A between 2000 and 2009 conveys something of the challenges of information-sharing and interagency working. Similarly, Adult A had intermittent contact with individual NHS clinicians in different clinical specialties, in different parts of the country. Nonetheless, not all clinicians in all services were familiar with Adult A's medical history. Broadly, it appears that professionals within single agencies made the contributions expected of their profession. Given the circumstances, they could not embark on multi-agency work because of the scarcity of evidence, which each had, individually for doing so.

Adult A's mental capacity and decision-making

Although there is some question about the nature of some of A's decisions, no documented professional assessment of his mental capacity was undertaken. There were occasions, however, when Adult A made conscious decisions which rendered him vulnerable to harm and abuse, for example, when he:

- breached bail conditions, failed to appear before Magistrates and did not attend probation supervision, even though the consequences included arrests, prison, probation and fines;
- absented himself from hostel accommodation, (which compromised his eligibility for subsequent hostel accommodation), and became homeless;

- was advised by his Probation Officer to contact the police because of threats of violence, but did not do so;
- reported to the police that he was a victim of an assault, but declined to seek the medical help that they advised and then to get back in touch when he had received it;
- was advised by a GP to attend counselling, but declined to do so;
- expressed concern regarding STIs and HIV which was not matched by a willingness to discover the outcome of tests;
- told his social worker and the police that he wanted protection from Adult B and yet returned to Adult B's family home and associated with him in public in a manner which suggested to professionals that he was fine, and even *happy*;
- when a Job Centre Clerk expressed concern about Adult A's injuries and gait, Adult A claimed that these were the result of being involved in *a fight*. This was the last occasion when Adult A was in contact with a professional. The Clerk offered him a lifebelt and yet Adult A pushed it away.

Individually and collectively, Adult A made many "unwise decisions." While it is known that different decision-making scenarios call for different skills, Adult A's decision-making was largely compromised by Adult B's influence. Location, timing and the presence of others matter in decision-making and, retrospectively, there is acknowledgement that professionals should have been more attentive to these factors. In terms of Adult A's response to and engagement with medical treatment, it seems possible that his behaviour manifested *unwillful dissent* (Grisso and Vierling 1978), i.e. saying "no" and not accepting help from adults. In Adult A's dealings with all services however, his refusal was consistently taken at face value.

Yet it was known that Adult A was using drugs and had disclosed to a GP that he had been hearing voices for two years - factors which might have affected his capacity to the extent that he was unable to make particular decisions. Arguably, the above incidents should have alerted services to the fact that Adult A's decision-making may have been compromised by a range of factors which also rendered him vulnerable, (see below).

With regard to Adult A's decision-making it is clear that he was seen by some professionals as having mental capacity with the ability not only to make, but to act on his decisions and assume the consequences. In retrospect, this perception appears to have been formed from a superficial examination of Adult A's conduct, conversations and circumstances. Indeed, there is no documented evidence that an assessment of his capacity in relation to any of the array of decisions outlined above, was ever made. Whilst the Mental Capacity Act 2005, which provides a framework for decision-making in respect of people over 16 who lack capacity to make decisions about finances, health and welfare, presumes individuals to have capacity, this does not and should not mean that professionals are exempt from asking challenging and searching questions in relation to individuals who are making choices that are problematic. The presumption of capacity does not exempt authorities and services from undertaking robust assessments where a person's apparent decision is manifestly contrary to his wellbeing. The law states that a person will lack capacity if, on balance of probability

they are unable to understand information about a decision (including the reasonably foreseeable consequences of making that decision or not), weighing information in the balance in order to reach a decision and to communicate a decision. Case law confirms that a person's ability to use and weigh information may be significantly compromised as a result of the actions of third parties who place unnecessary pressure on them to refuse such interventions as health or social care support. Yet, despite a series of reports by Adult A, and others, of coercive behaviour towards him by Adult B, its impact on Adult A's decision-making (not to press charges, to change residence, to disengage from support services, to return to Luton with Adult B), was not examined for its potential to affect Adult A's decision-making.

The assumption that Adult A had capacity seemed to prevail in every service that had contact with him. Whilst professionals are tasked to act reasonably in making determinations of incapacity and, in the event of a finding of incapacity, acting in an individual's best interests, in retrospect, it is questionable whether or not the across-the-board assumption that Adult A had capacity was reasonable.

Adult A's vulnerability

At different stages in Adult A's *adulthood*, certain professionals believed he was vulnerable. Legislation such as the Care Standards Act 2000, Youth Justice and Criminal Evidence Act 1999 and the Safeguarding Vulnerable Groups Act 2006 provide different definitions of the term "vulnerable." The definition set out in *No Secrets* (Department of Health 2000) comes from the NHS and Community Care Act 1990, i.e. it is grounded in the duty of local authorities to assess people's needs for community care services. Furthermore, statutory guidance on Fair Access to Care states that abuse and neglect constitute "critical" or "substantial" community care needs for the purpose of local authority intervention. Broadly, agencies' considerations of Adult A's "vulnerability" follow the legislation and specifically the NHS and Community Care Act 1990. However, Adult A was deemed ineligible for Adult Social Care services. Nevertheless, agencies in describing Adult A also alluded to such dictionary definitions as *capable of being wounded; liable to injury or hurt to feelings; capable of being persuaded or tempted;* and *exposed to being attacked or harmed either physically or emotionally.* There were occasions, on the other hand when, as an adult, Adult A positioned himself interpersonally in ways that indicated to some professionals that he was *not* "vulnerable." This is not to imply that all professionals were immune to non-legislative considerations of vulnerability. At different stages of Adult A's life he was known as an alleged child sex offender, a care-leaver, homeless, a glue sniffer, a user of cannabis, an associate of criminals and responsible himself for crimes against the person, against property and crimes of theft, long term unemployed and latterly, as experiencing auditory hallucinations. Such roles powerfully affected some professional judgements about his vulnerability.

Conclusions

"…training young people to be independent, to survive on their own, has become an important issue in contemporary leaving care policy. Yet research findings should make us

question this – particularly the evidence of loneliness, isolation and the eventual breakdown of young people living alone…We should…seek to learn more from the existing patterns of 'good' parenthood…question the qualitative dimensions of independence training with its emphasis upon practical survival and emotional detachment at the expense of personal development and interpersonal skills…For local authorities the most important issues raised by research are those which identify their failure to behave as a caring parent and the possibilities open to them to do so" (Stein, 1989, 211-212).

This is an unusual SCR since Adult A was not "vulnerable" according to legislative definitions. At the murder trial, Judge John Bevan described Adult A as "vulnerable" and, allowing for variations, his evaluation echoes that of most of the professionals with whom Adult A was in contact. It is possible that Adult A developed undiagnosed mental health problems but neither his history nor serial homelessness (including refusals of help) resulted in heightened professional concern or credible intervention.

Adult A's limited efforts to escape from Adult B, which began in a children's home, went unheeded. Ultimately, he was believed to acquiesce in his humiliation and to remain inert in the face of annihilating assaults. His traumatic childhood rendered Adult A literally and emotionally abandoned without consistent or predictable guidance. His support in residential care and as a care-leaver was severely wanting but, as Stein (1989) noted, care-leaving services were not fit for purpose. Too much was expected of Adult A as a 16 year old – a young person in that unspecified period between adolescence and adulthood – when he had neither the maturity nor judgement to identify the safe companionship of trusted others. Even in 2011, the time frame for after care appears unduly brief.

Finally, it is difficult to regard Adult B's family as anything other than a caricature of the *neighbours from hell.* Their anti-social behaviour was wide ranging, taking in the use of fire arms, racial harassment, threats of, *inter alia*, violence and *fire-bombing* homes, noise nuisance and motor bike nuisance. They were subject to serial evictions and some neighbours were offered places of safety. Adult B is not in the foreground of this Serious Case Review. However, neither Adult B nor his family benefitted from accepted wisdom in child welfare and youth justice which holds that early intervention is crucial to achieving good outcomes (see, for example, Home Office, 1997; and Department for Education and Skills, 2004).

Recommendations

1. **That the "case study" of Adult A's circumstances feature in training in Luton's children and adult services:** Adult A's pitiless early life was not ameliorated by professional intervention and his admission into care offered nothing substantive in terms of planning or benevolent possibilities. This was a time during which he discovered that he was neither deeply special nor important enough for adults to show him that there was a better place to be. He was functionally alone and there was no sustained interest in his welfare when he ceased to be the responsibility of children's services.

2. **That the Serious Case Review is shared with Bedfordshire Police, the Probation Service, the PCT - GP consortia, Social Landlords, Bedfordshire Housing Sub Region Partnership, care leavers' services and services for homeless people and is promoted by local authority members with a view to creating a forum for training and development:** Accommodation looms large in considerations of care leavers' circumstances. Adult B's family were constantly brought to the attention of Tenancy Enforcement and yet they persisted in terrorising their neighbours. Unsustainable tenancies have consequences for many areas of social and public policy. Learning from the conjunction of events which led to Adult A's murder is a fitting way of remembering Adult A.

3. **That Luton's Safeguarding Vulnerable Adults Board promotes training in (i) assessing mental capacity and decision-making and (ii) risk assessment and risk management:** situated assessments pervaded and influenced Adult A's contacts with services. These depicted uncertainty.

4. **That Luton's Children's Safeguarding Board invite Children and Learning to outline how their obligations to young care leavers and prospective care leavers are being enacted:** via (i) strategic and operational links with Adult Social Care and (ii) by preparing brief case studies which reflect *the coordination* of engagement across services as well as evidence of planning for and with young people.

5. **That the Children's Safeguarding Board invite schools and residential services to report on their preventive work to reduce bullying, their knowledge of its effectiveness, and to establish that sexual bullying features in all anti-bullying policies**. For most of Adult A's life he was plagued by bullying. Although teachers and children's services knew that Adult A was subject to sexual bullying in school, in residential and foster care, there was no outcome focused effort to address this.

6. **That Children and Learning identify care leavers who are without supportive and trusting relationships with birth or chosen families, who are at risk of becoming homeless and focus multi-agency attention and resources on them:** Adult A's homelessness was not transitional. His numerous addresses confirm that homelessness punctuated his late adolescence and adulthood. He was at risk of violence and victimisation on the streets. Such difficulties and dangers demanded Adult A's vigilance and ingenuity or *street wisdom* – which perhaps implied self-sufficiency rather than the realities of chronic exhaustion, unemployment, depression, hunger, drugs, exploitation, street prostitution, street crime, and chronic health problems. Profoundly disadvantaged care leavers require on-going and relationship-based, professional support. Even at its best, "corporate parenting" ceases for care leavers at 21.

7. **That the Serious Case Review is shared with the Chief Police Officers of the Bedfordshire, Cambridgeshire, Lancashire and Norfolk to determine**

whether or not ACPO Guidance is required: although Adult A was known to each of these constabularies, one believed that he had a learning "difficulty," there were unresolved concerns regarding the appropriateness of accessing an appropriate adult for him, fact-finding about him was limited and he was a victim of mistaken identity.

8. **That Luton's Safeguarding Vulnerable Adults Board presents this Serious Case Review to the Law Commission**: The array of risks to which Adult A was exposed as a care leaver, a young adult and an offender were known to more than one agency. Retrospectively, the considerable duress to which Adult A was subject *might* have come to light had there been a system akin to MAPPA for such adults "at risk." To illustrate the challenges of not having such a system, some professionals appeared to conflate capacity and vulnerability and while there is some overlap, the two are not coterminous. Vulnerable people may lack capacity and people lacking capacity may be vulnerable, but not always. And there are individuals who have capacity who may yet be vulnerable (as in Justice Munby's deliberations: *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (FAM)). Further, professionals appeared to assume that if no questions are asked about capacity and there is no evidence, then capacity may be presumed.

References

Brammer, A. (2006) *Social Work Law* 2nd Edition, Harlow: Pearson Education

Braye, S. and Preston-Shoot, M. (1997) *Practising Social Work Law,* 2nd Edition, Basingstoke: Macmillan

Department for Education and Skills (2004) *Every Child Matters: The Next Steps,* London: The Stationery Office

Grisso, T. and Vierling, L. (1978) Minors' consent to treatment: A developmental perspective *Professional Psychology,* 9, 412-427

Home Office (1997) *No More Excuses,* Cm 3809, London: The Stationery Office

Liu, J., Francis, B. and Soothill, K. (2007) *The risk of escalation in serious crime for kidnap offenders: A modelling approach,* University of Lancaster: Centre for Applied Statistics, Economic and Social Research Council National Centre for Research Methods, Working Paper Series 4/07

Macaskill, C. (1991) *Adopting or fostering a sexually abused child,* London: Batsford

National Children's Home (1991) *The Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children* London: National Children's Home

Stein, M (1989) Leaving Care. In B. Kahan (Ed.) *Child Care Research, Policy and Practice*, London: Hodder and Stoughton in association with the Open University

Stein, M and Carey, K (1986) *Leaving Care,* Oxford: Basil Blackwell

Utting, W. (1991) *Children in the Public Care: A Review of Residential Child Care,* Social Services Inspectorate, London: HMSO

Williams, J. (1995) *Social Services Law,* 2nd Edition, Croydon: Tolley Publishing Company Ltd.