Summary Serious Case Review Adult G

This Serious Case Review (SCR) was commissioned by Luton Safeguarding Adults Board (LSAB) following the tragic murder of Z. It was written by Dr Paul Kingston and Dr Edward Tolhurst of Gerontological Concerns Ltd, utilising the chronologies of each of agency's contact with G and other relevant parties. The agencies involved were:

- Luton Borough Council
- Bedfordshire, Cambridgeshire and Hertfordshire Police Major Crime Unit Review Team
- South Essex Partnership University Mental Health Trust*
- NHS Luton Clinical Commissioning Group including G's GP
- Luton and Dunstable Hospital NHS Trust

* The Luton Mental Health and Wellbeing Service is now provided by East London NHS Foundation Trust (ELFT)

The two main individuals considered in the SCR are semi-anonymised as G (the perpetrator), and Z (the victim).

Circumstances leading to the Serious Case Review

On the afternoon of Tuesday 22nd October 2013, Z was fatally stabbed in the garage of his home in Luton. G was arrested for murder later that evening having given himself up to Police in Ryton near Coventry. Although there had been reported domestic abuse between G and his previous partners, this event on 22nd October was a random attack. However, since July 2012 and up to the day before the murder of Z, information obtained by the Police gave rise to concerns about G's radical religious views potentially putting him at risk from others in the community who would not agree with his views. This coincided with the deteriorating condition of his mental health. The criminal trial concluded in 2014 with G pleading Guilty to Manslaughter by way of Diminished Responsibility. He has received a custodial (hospital) sentence.

The Luton Safeguarding Adults Board made the decision to hold a SCR because G was known to some agencies and hindsight indicates that although G had no prior involvement with secondary mental health services, earlier and different action by agencies might have prevented this tragic murder.

Concerns about G were reported to the Council's Safeguarding Team at the beginning of September 2013 following a visit by the Police to his home in August 2013. These concerns centred on a planned public lecture that G had told police he was going to hold in the middle of October. G had also written a number of religious ideological books and sent emails to members of the Muslim Community and the concern was that his ideology could cause offence and that giving a public lecture would put him at risk.

The Safeguarding Team requested a mental health assessment. However there were delays in the Mental Health Trust becoming involved and their Crisis Resolution and Home Treatment Team (CRHTT) had only started to engage and assess him in the days (18th and 19th October) immediately preceding the murder.

On 21st October G made further contact with the Police by e-mail and phone. The content of the email and 25 minute phone call, which was terminated by G, contained extreme religious

ramblings and threats. Following this the Police attempted to visit G at his home but he refused to let them in and they believed they had no power of entry. The Police spoke to a person they believed was G's lodger who indicated everything was alright. The police also spoke to staff in the CRHTT who attempted to make telephone contact with G to arrange a home visit. However CRHTT staff were unsuccessful in making contact by phone or when they made a home visit (cold call). The agreed plan was for a further visit to be arranged.

The Serious Case Review

The 36 page report includes the following sections: the Terms of Reference for the Review, the Methodology used, Facts and Key Events prior to the Review, Findings, Conclusions and Recommendations as well as tables listing materials scrutinised and references. The report considers in detail all contact by all agencies with G and other relevant parties since 2009 (1996 for GP records) and what information was shared/not shared within and between agencies and what action was taken/not taken. It also considers how people expressing extremist religious views where there may be mental health issues should be managed.

Findings and Recommendations

In this case the report writers found that:

- as in many other SCRs the failure to share information across agencies was a significant factor in the tragedy *as staff can only act on the information that is available to them at the time* (recommendations f, g and i);
- the use of different forms to capture concerns about 'vulnerability' and 'safeguarding' obscured concerns and delayed action (recommendations b-e);
- the case highlights the need for partner agencies to be more aware of the significance of extreme opinions and or religious views held by individuals and the risks these may pose especially when concerns about violence, including domestic violence, have also been made (recommendations h and i).

They concluded that there was a systematic failure across the agencies responsible for safeguarding to address G's longstanding mental health condition which they believe required attention as far back as 2011. His mental health deteriorated further in 2013 to the extent that G became a danger to himself and by 21st/22nd October also a danger to the public, resulting finally in the catastrophic incident. Despite failings by agencies the report writers praised the outstanding work of one police officer involved in the case.

The SCR report writers made ten recommendations which have been accepted by the LSAB. These are included here in full.

a) Individual agencies should have a 'first point of contact' named individual responsible for actioning 'Safeguarding' concerns. This role should mirror the role suggested under section 14.101 of the Care and Support Statutory Guidance: Issued under the Care Act 2014 (DoH, 2014); [ALL]

b) The process and forms utilised between the Police Force Public Protection Unit and the Safeguarding Systems in other agencies within the local health and social care geography should be made formal and explicit; [ALL – but should be led by LSAB]

c) Prompt efforts should be made to develop a ‘common nomenclature’ to describe the work considered as ‘Adult Safeguarding’ in the main agencies working in this field. This should include a thorough review of policies/protocols and any systems of referral, paper or other that are commonly used by agencies. It is especially important to have consistent referral mechanisms, whether electronic or hard copy; [ALL but led by LSAB]

d) The ‘Safeguarding’ structure in Luton should revisit how policies and procedures assist agencies to differentiate concerns of a ‘vulnerability’ nature from disquiets of a ‘safeguarding’ category (or adults at risk using Care Act nomenclature); [ALL but led by LSAB]

e) The ‘Safeguarding’ structure in Luton should consider how multi-agency cooperation can be facilitated and enhanced; [LSAB]

f) Police sharing of intelligence on extremism or religious extremism needs urgent consideration; [POLICE]

g) Police agencies should evaluate their procedures for sharing intelligence and most importantly methods for allocation of accountability to act on this intelligence; [POLICE]

h) Consider how the statutory agencies after 1st April might respond to concerns related to ‘Safeguarding concerns’, and overlaps with extreme opinions of an extremist or religious nature; [ALL, LSAB]

i) Information sharing systems between all agencies connected with Safeguarding in Luton should be assessed for their ‘Fitness for purpose’; [ALL led by LSAB]

j) Mental Health Services should assess what mechanisms are in place to differentiate ‘mental health sequelae of a religious presentation’ from ‘extremist religious opinions’ found in an individual with ‘other’ mental health challenges. [note there is a growing literature in this area, for example see Borum, 2014]; [to be actioned by East London NHS Foundation Trust (ELFT) the new Mental Health Service Provider]