

**BC / 2012**

**Domestic Homicide Review**

**Overview Report**

## **Introduction**

This domestic homicide review (DHR) overview report examines agency responses and support given to Barbara Cole, a resident of Town A, Kent prior to her death on 20 May 2012 at the hands of her son Ryan Cole. It also considers agencies' contact and involvement with him.

The key purpose for undertaking this DHR is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

## **Timescales**

The review began on 11 June 2012. It was suspended from 1 August 2012 to 12 November 2012 following advice from the Crown Prosecution Service (CPS) that it could prejudice the criminal trial of Ryan Cole.

## **Publication**

This report is publicly available and can be found on the websites of both Kent and Medway Community Safety Partnerships

## **Anonymisation**

The report has been anonymised and all the personal names contained within it, with the exception of references to members of the review panel, are pseudonyms. In the case of children referred to in the report, the anonymisation ensures that their gender is not disclosed.

# Kent Domestic Homicide Review Panel Overview Report

## 1. Introduction

1.1 This report is an anthology of information and facts gathered from 12 agencies. It does not disclose any evidence that Barbara Cole was a victim of domestic abuse prior to her death and the issue of support for her in that regard is not applicable. Only three agencies have records of contact with Barbara in the years leading up to her death:

- Surgery 2, Town A, Kent
- Kent NHS Community Healthcare Trust
- Kent County Council Specialist Childrens Services

1.2 These contacts are set out in Section 3 of the report but they are not related to her death.

1.3 Ryan Cole had contact with all 12 agencies between 1 January 2005 and the date he killed his mother:

- Kent Police
- Sussex Police
- Surrey & Sussex Probation Trust
- Kent Probation Trust
- Surgery 1, Town B, West Sussex
- Sussex NHS Partnership Trust
- Surgery 2, Town A, Kent
- Kent & Medway NHS Social Care & Partnership Trust
- Kent NHS Community Healthcare Trust
- Kent County Council Specialist Childrens Services
- East Kent Services (Housing)
- Kent Fire & Rescue Service

1.4 The contact and involvement that Ryan had with these agencies is set out in detail in Section 3 of this report and where relevant, an analysis is contained in Section 4.

## 2. The Review Process

### 2.1 Review Panel

2.1.1 The review panel was made up of an Independent Chair and senior representatives of the agencies that had relevant contact with Barbara Cole and/or Ryan Cole, together with the Kent & Medway Domestic Abuse Co-ordinator and a senior member from each of Kent County Council and Medway Council Community Safety Teams. The members of the panel were:

Paul Brightwell	KCC Children and Adult Services
Andrew Coombe	Kent and Medway NHS
Tim England	Medway Community Safety
Alison Gilmour	Kent & Medway Domestic Abuse Co-ordinator
Tina Hughes	Kent Probation
Paul Pearce	Independent Chair
Shafick Peerbux	Kent Community Safety
Andrea Saunders	Surrey and Sussex Probation
Tim Smith	Kent Police
Cecelia Wigley	Kent and Medway Partnership Trust

2.1.2 The Chair of the panel is a retired senior police officer (who did not serve with Kent Police) who has no association with any of the agencies represented on it. He has experience and knowledge of domestic abuse issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to tackling domestic abuse. He has a background in conducting reviews and investigations, including those involving disciplinary matters.

### 2.2 Review Meetings

The Review Panel first met on 31 July 2012 to discuss the terms of reference, which were then agreed by correspondence. Following the criminal trial a briefing was held for IMR writers on 19 December and the Review Panel then met on 27 March 2013 to consider the IMRs. The next meeting of the Panel was on 5 June when this Overview Report was considered in draft form and amendments agreed.

### 2.3 Family Involvement

2.3.1 The Review Panel considered which family members should be consulted and involved in the review process. The following have been contacted:

<b>Name</b>	<b>Relationship to Barbara Cole</b>	<b>Relationship to Ryan Cole</b>
Barry Cole	Husband	Father
Eileen Parker	Mother	Grandmother

Simon Parker	Father	Grandfather
Simon Parker	Brother	Uncle
David Parker	Brother	Uncle
Mary Hammond	Sister	Aunt
Louise Cole (nee Smart)	Daughter -in-Law	Ex-wife and mother of Ryan's child.
Lisa Prout	N/A	Mother of Ryan's Children

- 2.3.2 Initially the Chair wrote to Barbara's husband, her parents and her two brothers. Following a telephone conversation with her brother David, the Chair wrote to Mary Hammond, as it was not previously known that Barbara had a sister. On 13 February 2013 the Chair had a meeting with the family at the home of Barbara's parents. They were both present, as was Barry Cole and her brother David, who explained that Barbara's brother Simon and her sister had received the letters but were unable to attend the meeting. They were content for David to feed back what was said at the meeting.
- 2.3.3 The Chair explained the review process to the family members at the meeting and they were given copies of the Home Office DHR leaflet for family members. He was able to answer questions they had and to advise them that he would be able to meet with them again to discuss the draft Overview Report.
- 2.3.4 Family members provided some very useful background information in terms of both fact and opinion, and where relevant to the terms of reference this has been included in the report. Those spoken to confirmed that Barbara had not been a victim of domestic abuse by Ryan or anyone else prior to her death.
- 2.3.5 Following the meeting, the Chair wrote to Louise Cole and Lisa Prout having confirmed their addresses, but neither responded.
- 2.3.6 The Chair wrote to family members again following the completion of the draft Overview Report agreed by Review Panel. On 31 July 2013 he met with Barry Cole and discussed the findings and recommendations of the review with him. On 19 August the Chair similarly met with Barbara's parents and her brother Simon. Her sister and second brother were unable to attend the meeting and were again content for Simon to provide feedback to them.

### **3. Terms of Reference**

This section sets out the terms of reference for the review:

#### **3.1 The purpose of this DHR**

- i. Establish what lessons are to be learned from the death of Barbara Cole in terms of the way in which professionals and organisations work, individually and together, to safeguard victims.
- ii. Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.
- iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.
- iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

#### **3.2 The focus of this DHR**

- 3.2.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Barbara Cole.
- 3.2.2 If domestic abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.
- 3.2.3 If domestic abuse was identified, this review will focus on whether the agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if such abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practise. The review will examine how any reported incidents were recorded and what information was shared with other agencies.

#### **3.3 Methodology**

- 3.3.1 This review will be based on Individual Management Reports (IMRs) provided by the agencies which were notified of, or had contact with, Barbara Cole and/or Ryan Cole in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Barbara Cole or Ryan Cole, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.
- 3.3.2 IMRs will include a chronology and, if relevant, a genogram, and analysis of the service provided by the agency submitting the IMR. The IMR will highlight both

good and poor practise, and will make recommendations for the individual agency and, where relevant, for multi-agency working.

The IMR will include issues such as resourcing/workload/supervision/support and the training/experience of the professionals involved.

3.3.3 When each agency submitting an IMR has done so in accordance with the agreed timescale, each IMR will be considered at a meeting of the DHR Panel and an Overview Report will then be drafted by the Chair of the panel. This will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

3.3.4 The review will primarily focus on Barbara Cole and Ryan Cole: any information held by agencies taking part in the DHR may be relevant to the review. In addition, those agencies should search for any information they may hold on the three children known to have been fathered by Ryan Cole. They are:

<b><i>Alias</i></b>	<b><i>Year of Birth</i></b>	<b><i>Mother's Name</i></b>
<i>Child E</i>	<i>2000</i>	<i>Louise Cole</i>
<i>Child C</i>	<i>2009</i>	<i>Lisa Prout</i>
<i>Child D</i>	<i>2011</i>	<i>Lisa Prout</i>

3.3.5 If information is found that relates to concerns that one or more of these children were subject to domestic abuse, or that one or more of them were living at an address where domestic abuse was taking place against another person, the agency should consider this in the IMR/report submitted as part of the DHR.

3.3.6 In considering the victim chronology contained in the IMRs the relevant time period will begin on 1 January 2005 and end at the time of Ryan Cole's arrest. Notwithstanding this, any other information outside of those time periods should be included if it is felt that it may be relevant. Such information may include previous incidents of violence, alcohol or substance misuse, and mental health issues relating to either or both Barbara Cole and Ryan Cole.

3.3.7 Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

### **3.4 Specific Issues to be addressed**

3.4.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

- i. Were practitioners sensitive to the needs of both Barbara Cole and Ryan Cole, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- ii. Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Barbara Cole and Ryan Cole? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Barbara Cole subject to a Multi-Agency Risk Assessment Conference (MARAC)?
  - iii. Did the agency comply with information sharing protocols?
  - iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
  - v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
  - vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Barbara Cole and Ryan Cole (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
  - vii. Were senior managers or other agencies and professionals involved at the appropriate points?
  - viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
- 3.4.2 Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Barbara Cole and promote her welfare, or the way it identified, assessed and managed the risks posed by Ryan Cole? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working and/or training?



## **4. The Facts**

### **4.1 Introduction**

4.1.1 In this section, the recorded facts of Barbara's and Ryan's involvement with agencies are set out by service rather than individual agency. Within the sub-sections dealing with each service's involvement, the facts are set out chronologically.

### **4.2 The Death of Barbara Cole**

4.2.1 Barbara Cole lived in a house on the outskirts of Town A, Kent with her husband Barry. At 10.17pm on Sunday 20 May, Kent Police received a call from a friend of Ryan's partner Lisa Prout, telling them that Ryan had gone to his mother's house where he had killed her. She also told them that he was intending to kill his father, who he expected to arrive home imminently.

4.2.2 When police officers arrived at the house they discovered that it was insecure, and on entering they found blood on the floors and walls. Ryan was not in the house but he returned a short time later and he was arrested. At the time he made a comment about having a licence to kill his mother. Using his keys, officers found the body of Barbara under a duvet in the garden shed.

4.2.3 At the post mortem, the pathologist found that Barbara had been struck with a blunt instrument but that the cause of her death was strangulation.

### **4.3 Conviction and sentencing of Ryan Cole**

4.3.1 On 12 November 2012, Ryan Cole pleaded guilty to manslaughter on the grounds of diminished responsibility and he was sentenced to be detained indefinitely under the Mental Health Act 1983. Two psychiatrists had concluded that he suffered from a complex set of delusions and although a heavy and regular user of cannabis, this was not solely to blame for his mental illness.

### **4.4 Living arrangements and family – Barbara Cole**

4.4.1 At the time of her death Barbara Cole (nee Parker) was living with her husband Barry, who was Ryan's natural father. Ryan was their only child.

4.4.2 Barbara's parents, Simon and Doris Parker, also lived in Town A at the time of her death, while her sister and two brothers lived outside Kent.

### **4.5 Living arrangements and family – Ryan Cole**

4.5.1 At the time he killed his mother Ryan was living in Town A with his partner; Lisa Prout. They had two children together; Child A then aged 2 years and Child B, 11 months. Lisa also had two children; Child C aged 6 years and Child D, 4 years, by another man – Brett Taylor.

- 4.5.2 None of the children were living with the couple when Ryan killed Barbara as they were on a voluntary care plan agreed with Kent County Council Specialist Childrens Services (KSCS). Children A & B were being cared for by their maternal grandmother (MGM) and Children C & D by a maternal aunt. This arrangement was put in place at the end of November 2011 and the plan was to rehabilitate the children back with Lisa, who was intending to move to a new address in Town A without Ryan. This had not happened at the time of Barbara's death, and both Ryan and Lisa had access to the children as part of the care plan agreement.
- 4.5.3 Children A & B have the surname Black because in 2008 he changed his surname from Cole to Black by deed poll. Ryan is referred to as Cole throughout this report although agencies may have known him as Black through all or part of their dealings with him.
- 4.5.4 In addition, Ryan had a third child (Child E); then aged 11 years, from his marriage to Louise Cole (nee Smart). Louise also has a child (Child F); aged 13 years, by another man.

#### **4.6 Chronology**

- 4.6.1 Each agency that was required to produce an IMR included a detailed chronology of their dealings with Barbara and Ryan, an anonymised version of which is submitted with the Overview Report. In the case of Barbara, only three agencies had dealings with her and those that did come into contact with her did so on three occasions at most. During the period covered by the terms of reference Ryan had contact with all agencies that submitted an IMR.

#### **4.7 Agency Involvement – Barbara Cole**

- 4.7.1 None of Barbara's contacts with statutory agencies related to domestic abuse. She had no recorded contact with any third sector agencies, in particular those who support victims of domestic abuse.

##### *4.7a Health Services*

- 4.7a.1 Barbara visited her GP at Surgery 2, Town A three times in the 12 months prior to her death; the last being on 20 February 2012. On each occasion it was for physical conditions related to her general health, for which she was given treatment or referrals. One of these referrals was to a Kent Community Health NHS Trust (KCHT) physiotherapist, who she saw on two occasions in April and May 2011.
- 4.7a.2 In January 2012 Barbara visited the Minor Injury Unit at Town D Walk-In Centre, Kent, which is run by KCHT. This was again with a physical condition – tingling and changed sensation in the fingers of one hand.

4.7a.3 The records relating to Barbara's contact with health services do not contain any information that would suggest she was suffering from domestic abuse. Going back to 1993, her medical notes do not indicate any mental illness or distress. There are no entries relating to domestic abuse and no mention of Ryan.

#### 4.7b *Kent County Council Specialist Childrens Services (KSCS)*

4.7b.1 Barbara Cole's involvement with KSCS related to the voluntary care plan that was in place for the four children who had lived with Ryan and Lisa. Following agreement that a Family Group Conference (FGC) was appropriate, Barbara was contacted on 19 March 2012 by the FGC co-ordinator, who explained the process and arranged a home visit. This took place on 22 March when it was recorded that Barbara asked, *'...if there is any help for Ryan as he will be evicted very soon and how this will affect his contact with the children?'*

4.7b.2 The FGC took place on 27 March and both Barbara and Barry were present. As part of the plan agreed there, Ryan's parents were to be fully involved in increasing his access to the children. This included Ryan taking the children to their home, his parents inspecting his house on a weekly basis to ensure it was clean and tidy, and them having hands-on involvement with the children. It was also agreed that Barbara would be allowed to attend further KSCS meetings about Ryan's children and that 'police checks' would be made on her and Barry.

4.7b.3 The record of the FGC suggests that Ryan's parents, and Barbara in particular, were keen to assist their son in having increased access to his children. The most telling comment recorded in that regard was, *'His mother, upon inspection of [Ryan's house] on 15/04/12 will then provide carpets and furniture but only if the house has been fully cleaned and painted.'* There is no record of whether the 'inspection' took place but there is further mention during a home visit to Ryan and Lisa by a social worker on 15 May that she and Barbara were, *'... to monitor the home conditions.'*

#### 4.7c *Mention of Barbara Cole to Agencies*

4.7c.1 There are five records of Ryan referring to her when speaking to professionals.

4.7c.2 On 27 February 2006, while he was living in Town B, West Sussex, Ryan presented at Redhill Hospital A&E department following self-harming and was seen by the on-call psychiatrist. Among the issues he raised about things that were concerning him, it is recorded in clinical notes that he, *'Informed on-call doctor that he does not talk to his mum, that he dislikes her and hates her for having had an abortion which has left him with no brothers or sisters.'* There is no evidence or information to support Ryan's assertion that Barbara had had an abortion.

- 4.7c.3 In November 2007 a Probation Service Officer (PSO) working for Surrey & Sussex Probation Trust (SSPT) records that Ryan would be, '*...moving soon from [Town B] to live near his mother in Kent who he reports to have a reasonable relationship with.*'
- 4.7c.4 On 21 June 2010 Ryan was seen by a GP in Town A who noted, '*...that he was angry over previous child abuse and not being supported by his mother at the time.*' Ryan alleges that he was a victim of physical and/or sexual abuse a number of times during the period covered by the terms of reference and the way in which these allegations were dealt with are considered when analysing agencies' responses.
- 4.7c.5 On 22 March 2012 the FGC co-ordinator recorded that, '*Ryan thinks it is good that that his mother can now attend [the FGC].*'
- 4.7c.6 On 15 May 2012, five days before Ryan killed Barbara, a social worker visited the home he shared with Lisa. She recorded that he said, '*... [Barbara] was not his birth mother as his mother and father were too old to have them*'. The context in which he said this was not recorded.
- 4.7c.7 In summary, he expressed anger about his mother twice, made two positive references to her and one neutral comment. Barbara was not present on the occasions when Ryan made these references to her.

## **4.8 Agency Involvement - Ryan Cole**

### *4.8a Education*

- 4.8a.1 Ryan was born in Town A and according to his father he had learning difficulties and dyslexia as a child. He went to three schools in the town; infant, junior and a Special School. The latter is a day school for pupils with special needs aged 5-16 years and Ryan's attendance there indicates that his learning difficulties were recognised.
- 4.8a.2 This report will not analyse Ryan's education further as it is not relevant to the terms of reference.

### *4.8b Kent Police and Sussex Police*

- 4.8b.1 Ryan's first criminal conviction was in 1999 resulting from him taking a car belonging to a neighbour of his parents without consent and crashing it.
- 4.8b.2 In August 2000 a 16 year old ex-girlfriend of Ryan reported to Kent Police that he had raped her twice when she was 14 and they were boyfriend and girlfriend. The circumstance of the report was that patrolling police officers stopped a car in which the complainant was a passenger and it was then that she made the disclosure. It was not recorded as a crime, the disclosure was never put to Ryan and it is probable that he is unaware to this day that the complaint was made.

- 4.8b.3 In January 2001, when Ryan was living with his wife Louise in Town A, Kent Social Services reported to Kent Police that they had received information that Child F (then 2 years old), had unexplained bruising on its face and legs. Child F was living with its natural father, who noticed the injuries after Child F had an access visit to Louise and Ryan. This was investigated and the couple were interviewed by police. There were varying explanations about how the injury was caused and the medical evidence was inconclusive. On the basis that there was insufficient evidence to support a prosecution, the case was closed by Kent Police.
- 4.8b.4 By 2002 Ryan and Louise had separated and he had a relationship with a woman named Sandra Hart. During that year he was given a harassment warning after making threatening telephone calls to Louise. He then destroyed her mobile telephone (which he apparently got via Sandra's child) with a hammer and posted the remains through her letter box with a note stating, *'You will not get married, the vows, til death do you part.'* Ryan was arrested for damaging the phone and he admitted this. He received a caution but there is no record of any action being taken about the threatening contents of the note.
- 4.8b.5 In August 2002 Louise made a further allegation that Ryan was making menacing telephone calls to her, in which he said that he was going to kill her and Child E using a gun he had purchased in Scotland. Louise did not believe that he would carry out the threat but felt that he intended her to believe it. Kent Police investigated but it was not until 2003 that Ryan was traced, arrested and cautioned for a making a malicious communication. He had denied threatening to kill Louise but said he had threatened to, *'...give her a f\*\*\*\*\* good pasting.'* There is no evidence that he ever had possession of a gun.
- 4.8b.6 In 2004 Ryan was living in Town B, West Sussex with his paternal grandparents. It is unclear why he moved from Town A but he did tell a psychiatrist that it was because he had assaulted his cousin. He did not stay with his grandparents for long but continued to live in Town B until late 2007, when he moved back to Town A. While living in Town B his life became extremely chaotic.
- 4.8b.7 The involvement that Ryan had with Sussex Police during his time in Town B centres on his relationships with two women: Louise Harris and Julie Black. Louise Harris shares her first name with Ryan's ex-wife but they are different people and in this report all references to Louise while he was living in Town B relate to Louise Harris. It is unclear when his relationship with her began and ended, although he did live with her for a time. He had no involvement with Sussex Police until their relationship was over.
- 4.8b.8 From the start of his relationship with Julie Black in late 2005, she and Ryan were involved in the harassment of Louise. From the incidents recorded by Sussex Police, it appears that Julie was main instigator of the harassment and this may have been because she believed that Ryan was still having a relationship with Louise. In 2005 Julie was twice cautioned for assaulting

Louise; on both occasions by punching her. On the first occasion Ryan was present and arrested but he was not involved in the actual assault.

- 4.8b.9 The harassment of Louise, who had learning difficulties, by the couple continued through 2006 although there is no further physical violence recorded. In October 2006 both were charged with harassment and in December they went to court and were bailed with a condition not to contact Louise. Ryan appears to have complied with this until the conclusion of the case on 9 July 2007, when he received a 12 month Community Order.
- 4.8b.10 Parallel to the harassment of Louise was police involvement in incidents arising from Ryan's relationship with Julie. This was tempestuous and it appears they made their neighbours lives a misery with constant rowing. Police officers attended on numerous occasions in the two years they were together and during this period Ryan was both a perpetrator and victim of domestic abuse, always involving Julie. None of the injuries he suffered or inflicted were serious and although both were arrested when allegations of assault were made, neither was prosecuted. On three occasions Sussex Police attempted to carry out domestic abuse risk assessments on Julie but none were fully completed because she declined to engage in the process.
- 4.8b.11 The last record of Ryan's involvement with Sussex Police was in August 2007 when officers attended a report that he and Julie were arguing and fighting outside their flat in Town B.
- 4.8b.12 The earliest record of Ryan returning to Town A was in November 2007 when he was recognised in the street by a police officer. His move back to Kent was marked by a significant decrease in his involvement with the police and his first substantive contact with them was in November 2008 when he was the victim of an assault committed by Brett Taylor, the father of Lisa Prout's children. Brett was arrested and charged with this assault and later that month Ryan was again the victim of an assault when a man, who was not known to him and who was never traced, punched him after accusing him of having his friend arrested.
- 4.8b.13 In September 2009, Ryan was dealt with as an offender when he received a harassment warning after he and Lisa threatened Brett Taylor. This was treated as a domestic incident because of Lisa's previous relationship with Ryan. A risk assessment was completed, which indicated there were no mental health issues identified. The risk was classified as 'standard'. The domestic abuse victim-focussed risk assessment used by Kent Police was SPECSS (Separation, Pregnancy, Escalation, Culture, Stalking and Sexual Abuse), which was widely used by agencies at that time.
- 4.8b.14 Two years later, in September 2011, Ryan was cautioned for hitting a man with a piece of wood. This was a part of a long running dispute about an unspecified rape allegation between Ryan and the victim, who suffered a minor injury.
- 4.8b.15 In December 2011 Ryan was interviewed along with Lisa about an eye injury suffered by Child D. Neither was under arrest, nor was either prosecuted, but

this incident is discussed in depth in the section detailing Ryan's involvement with Kent County Council Specialist Childrens Services (KSCS).

- 4.8b.16 At the time he killed his mother, Ryan was on police bail following his arrest in February 2012 on suspicion of causing criminal damage to a number of cars. Had he answered bail, no further action would have been taken as there was insufficient evidence to charge him.

#### 4.8c Health Services

- 4.8c.1 During his time in Town B, Ryan had his first recorded contact with health services about his mental health. This was with the Surgery 1 in Town B, West Sussex and the Sussex Partnership NHS Trust (SPT), which delivered mental health services in East and West Sussex.
- 4.8c.2 Ryan was registered at Surgery 1 from June 2004 – the earliest record of him living in Town B - until October 2008. The surgery was asked to provide an IMR but could not do so because the practice's computer system was replaced in November 2011 and they cannot retrieve computer records of previous patients. This has been raised as a concern with the Medical Director of NHS Sussex.
- 4.8c.3 The first contact Ryan had with SPT was in October 2005 when a GP from Surgery 1 (GP1) made an urgent referral to the Town B Community Mental Health Team (HCMHT), part of SPT. He had disclosed to GP1 that he was hitting his partner, smoking cannabis, in debt and that he had a history of being a victim of sexual and physical abuse.
- 4.8c.4 Ryan was referred to a psychiatrist (P1), to whom he disclosed his illiteracy and dyslexia. The conclusion of the consultation was that '*...[Ryan] suffered from borderline anti-social personality disorder traits along with associated psychotic symptoms*' and that an underlying depressive disorder could not be ruled out. He was prescribed medication (Mirtazapine) and asked to attend an anger management group. This assessment, carried out in November 2005, is the only recorded diagnosis of Ryan's mental health condition prior to him killing his mother.
- 4.8c.5 In January 2006 he met with the facilitator of the anger management group who offered him further 1:1 appointments before beginning group sessions. It is recorded that he attended the group sessions (although not how many) and the Occupational Therapist who facilitated them confirmed that the absence of a report by her back to the referrer indicates that she had no concerns. Ryan subsequently told a psychiatrist that he attended twelve sessions and that they had not worked.
- 4.8c.6 Later that month Ryan saw a consultant psychiatrist (P2) who advised him to continue taking his medication as it appeared to be working.
- 4.8c.7 At the end of February 2006 Ryan presented at Redhill Hospital in Surrey having self-harmed by cutting his forearms. He was seen by the on-call psychiatrist (P3) to whom he stressed that he was not suicidal. He reported

physical abuse by his father, and in respect of his mother it was on this occasion he said that he, *'hates her for having had an abortion which has left him with no brothers or sisters'*. He said he was in debt and that he had a history of hitting his wife and current girlfriend, but in the case of the latter it was, *'both ways'*. He also admitted anger management problems and a risk assessment was carried out, which identified that he was a risk to himself and others. P3 wrote to HCMHT enclosing a copy of his assessment and requested that they provide ongoing support.

- 4.8c.8 Ryan failed to attend appointments with psychiatrists and in May another GP from Surgery 1 (GP2) wrote to a HCMHT Community Psychiatric Nurse (CPN), *'... asking for additional support in addition to psychiatrist support and anger management [classes].'* In the absence of medical records from the surgery it is not clear what prompted this.
- 4.8c.9 Over the next 6 months there was a history of Ryan failing to attend appointments and he was not seen again by HCMHT staff until the end of September 2006. The CPN who he saw then recorded that his GP was prescribing Mirtazapine, although again the lack of practice records means that no other information is available about his GP visits during this period. HCMHT records state that the CPN re-referred Ryan to the anger management group and made an appointment for him to see a psychiatrist. There is no record of the former having been actioned, but in respect of the latter his case was reviewed by P2 in November 2006 when it was recorded that Ryan was *'...feeling ok...'* and he was advised to continue with his medication.
- 4.8c.10 In June 2007 GP2 asked HCMHT to get involved again due to Ryan's severe anger, debt and accommodation problems. GP2 recorded that, *'[He] feels he is about to enter another crisis'*. Due to an unspecified administrative error by HCMHT he was not seen until October 2007, this time by two CPNs. They identified mood and anger problems, and referred him to another psychiatrist (P4) who saw him about three weeks later. Anger again featured and he mentioned that his family were not on speaking terms with him - it was while he lived in Sussex that his parents changed their telephone number because he had been threatening them. He said that he got angry when people asked him to read because he was illiterate, and that he was on a suspended sentence for arranging for a woman to beat up his ex-partner – in fact he was the subject of a Community Order for harassing her. He expressed concerns about his ex-wife abusing their child; he had seen bruises on her wrist. He said that he was finding the anti-depressants unhelpful and P4 advised him to stop smoking cannabis. P4 recorded that he planned to refer Ryan to Addaction (a substance misuse support charity) and to chase the council regarding getting him housed, but there is no record that either was done.



- 4.8c.11 Ryan saw P4 again in November 2007, when he said that he had temporary accommodation in Town A and that he had not used cannabis for three weeks. He still experienced anger but had not been violent. He added that due to concerns he had expressed to Social Services about Child E, '*...they have now placed her on the child protection register*'. KSCS have no record that Child E was the subject of a child protection conference or a child protection plan. P4 advised him to register with a GP in Town A and discharged him.
- 4.8c.12 Ryan registered with the Surgery 2 in Town A in October 2008, almost a year after he had last engaged with health services. He was still registered with Surgery 1 until this time but the loss of patient records means that is not known whether he had any appointments there after moving to Town A. Ryan's registration with Surgery 2 followed a telephone call to a Kent & Medway NHS & Social Care Partnership Trust (KMPT) CPN (CPN1) made a week earlier by his partner – her name was not recorded but it was probably Lisa Prout - stating that he was self-harming. Ryan spoke to CPN1 during this call and having explained to her his treatment by HCMHT, he was advised to register with a local practice.
- 4.8c.13 Following his initial visit to Surgery 2 a GP there (GP3) recorded that Ryan suffered from chronic depression and had been treated for 4 years. She noted his history of self-harm, prescribed him Mirtazapine and referred him to a consultant psychiatrist.
- 4.8c.14 There followed a pattern of non-engagement with mental health services, which resulted in Ryan being discharged back to GP1 on 11 December 2008. The process used to try and arrange an appointment with him involved CPN1 sending him three letters; two with appointment dates, the other asking him to contact KMPT if he still required an appointment. He neither attended the appointments nor responded to the letters, resulting in his discharge.
- 4.8c.15 During this process, CPN1 requested Ryan's medical notes from HCMHT. This is shown by a copy of the facsimile request dated 1 December 2008, which was retained in the KMPT case notes. His records were not transferred and there is no record of a follow up request. KMPT were never aware of his detailed mental health history or of the diagnosis made in 2005.
- 4.8c.16 Ryan's next contact with health services was in March 2010 when he saw GP3 at Surgery 2. He was recorded as being depressed and appearing sad. He told GP3 that, '*...he had changed his name the previous year, due to chronic memories of child abuse.*' GP3 gave him a 6 week medical certificate and referred him for cognitive behavioural therapy (CBT). KMPT records dated 10 May state that this referral was incomplete and Ryan was placed on the waiting list for a screening appointment. There is no record of him ever having CBT but GP3's referral was passed to KMPT.
- 4.8c.17 On 6 May Ryan saw a locum (GP4) at Surgery 2. He was angry and frustrated, swearing a lot to begin with, and when he calmed down he asked to see a psychiatrist. He disclosed that he had been using cannabis for 10 years and,

*'...mentioned about child abuse'*. GP4 made an urgent referral to the KMPT local mental health team.

4.8c.18 The referrals from GP3 and GP4 arrived at KMPT on the same day; 20 May 2010. They were screened by a CPN and a letter was sent to Ryan with an appointment date. He did not attend so CPN1 and another CPN (CPN2) sent him further appointments by letter, which he neither attended nor acknowledged, and on 22 June he was discharged back to GP3. This discharge letter crossed over with a visit to GP3 made by Ryan on 21 June when told her that the appointment letters were going to the wrong address. It was on this occasion that he expressed anger over, *'...previous child abuse and not being supported by mother at that time.'* GP3 re-referred Ryan and on 25 June CPN1 telephoned him and made another appointment, which he subsequently telephoned to cancel.

4.8c.19 Attempts were made to rearrange the appointment, both by letter and telephone but following three more failures to attend Ryan said in a telephone call to CPN2 that he felt, *'...he no longer needed mental health input at this time.'* As a result, on 28 July he was discharged back to GP3. On the occasion of his referral to KMPT in 2010 no attempt to obtain his medical notes from HCMHT was recorded. Ryan had no further engagement with health services in his own right prior to killing his mother almost two years later.

#### 4.8d *Surrey & Sussex Probation Trust (SSPT) and Kent Probation Trust (KPT)*

4.8d.1 In July 2007, while living in Town B, Ryan was sentenced to a 12 month Community Order for the harassment of his ex-partner, Louise Harris. Attached to the order were a 12 month supervision requirement and 100 hours unpaid work. He complied with this order for the most part, and when he missed appointments he provided acceptable reasons and supporting evidence. When SSPT first engaged with Ryan, he disclosed physical abuse by his father and also said that he was taking anti-depressants. A letter from GP2 disclosed his mental health issues and anger management problems. A risk assessment said that he posed, *'...a low risk of serious harm'*, although a Spousal Assault Risk Assessment (SARA) relating to the potential risk to a partner or other family members, as required in cases involving domestic abuse, was not carried out.

4.8d.2 On 8 November 2007 Ryan told his Probation Service Officer (PSO1) that he had been, *'...offered accommodation in Kent, probably Town A'*, and that, *'...he wishes to resume contact with his [Child E] who lives in that area with his ex-wife.'* It was recorded that he intended moving, *'...to live near his mother in Kent who he reports having a reasonable relationship with.'* Two weeks later he told another member of the probation team that, *'...he has a flat in Town A and will confirm address next week.'* A further four days later the address he intended living at in Kent is entered on OASys (a National Offender Management Service computer software system) as his parents' home.

- 4.8d.3 Ryan's probation file was passed from SSPT to KPT in December 2007. The address he told PSO1 was living at in Kent was not confirmed or assessed for suitability by either probation trust.
- 4.8d.4 At his first meeting with KPT, Ryan told his Offender Manager (PSO2) that he had been living with his parents for 10 weeks while still attending SSPT. It is not clear how long he lived with them for after returning to Town A, but his father believed that he was going back to Sussex during that period to continue receiving treatment from MENCAP, which was not the case. He produced a medical certificate at the meeting, which stated that he was 'signed off' indefinitely for depression. This was signed by a GP (name not recorded) in Town C, West Sussex, which is a few miles from Town B. There is no record of Ryan having been registered with a GP in Town C at any time and he was still registered at Surgery 1 at this time. KPT records no longer contain a copy of this certificate. Ryan told PSO2 that, *'...it won't be a problem getting a GP in Town A as he would "invoke" the Mental Health Act and "get to the front of the queue."'*
- 4.8d.5 During the part of his Community Order that he served in Kent, Ryan said that he wanted to improve his literacy, to obtain a Construction Skills Certification Scheme card and to gain full time employment. He subsequently had a good record of attending Education, Training & Employment and Skills For Life appointments.
- 4.8d.6 In the final entry on OASys, PSO2 identified Ryan as posing a low risk of harm but also noted that this could increase should he return to Town B, if his emotional health deteriorated or if he experienced relationship problems with a different partner. He further noted that the risk might increase once the Community Order expired (on 7 July 2008) and the salutary effect of the sentence was lessened.
- 4.8e *Kent County Council Specialist Childrens Services (KSCS) and Kent Community Health NHS Trust (KCHT) Health Visiting Team*
- 4.8e.1 In June 2001 a health visitor (HV1) recorded that Louise Cole had reported that Ryan had been violent to her and had threatened to kidnap Child E. Ryan and Louise had stopped living together by this time but this is the earliest record of him being a domestic abuse perpetrator. HV1 reported this information to Kent Social Services but there is no record of what action, if any, was taken.
- 4.8e.2 From the time Ryan split up with Louise through to 2004 it is not known where he was living or what his domestic circumstances were. His father believes he went to Lancashire or Leicester for at least part of that time but this cannot be confirmed.
- 4.8e.3 KSCS first encountered Ryan on a home visit in September 2008 following a referral received from the paternal grandfather of Lisa Prout's children. The complaint concerned the living conditions at the house, including the allegation that it was being used for the selling of illegal substances. Although Ryan is not named, the children's grandfather, *'...further raised concerns about a man*

*described as a babysitter who is a drug dealer.*' Ryan was a cannabis user but there is no evidence that he was dealing in controlled drugs or that the house was used for that purpose.

- 4.8e.4 There is no record of this information being passed on to Kent Police but in response to it a social worker made an announced home visit and no concerns were raised about the care and presentation of the children. It was confirmed that Ryan was living with Lisa, having previously been a babysitter for her and her estranged husband, Brett Taylor. Both denied illegal substance misuse and as the complaint from Brett's father was unsubstantiated, the case was closed.
- 4.8e.5 In June 2009 Child D suffered a cut lip and bleeding nose at nursery school, which he said was caused by a teacher pushing the child. Ryan subsequently visited the nursery and became very angry and aggressive towards the manager. He mentioned that he had been beaten up at his school. A child protection enquiry under Section 47 of the Children Act 1989 was instigated following this incident and SW1 visited Lisa and Ryan at home in July 2009. When mention was made of Child D being incontinent at nursery, Ryan became very agitated, swearing about the nursery and gesticulating at the child, who appeared anxious. Ryan then left the room and when he returned in a much calmer state he was strongly advised by SW1 to address his temper in the presence of children, and he accepted and recognised this.
- 4.8e.6 It was about this time that the couple and Children C & D moved into the house in Town A where they lived until Ryan was arrested for killing his mother. The house is referred to in this report as the family home.
- 4.8e.7 On 24 September 2009 Lisa gave birth to Child A. The baby was five weeks premature and was admitted to the hospital's Natal Intensive Care Unit (NICU). A week after the birth Ryan went there and as a result of his behaviour, which included threatening to take the baby home that day (he did not), the member of the hospital staff who dealt with him, '*...began to suspect either mental instability or drug misuse.*' This incident was reported to KSCS and on 8 October 2009, SW1 and a health visitor (HV2) conducted a joint visit to Ryan and Lisa at home. Child A was still in hospital at this time and Ryan was much calmer. He apologised for his behaviour at the hospital and accepted that it was worrying if he behaved like that around children. The couple agreed to engage with the health visiting service.
- 4.8e.8 Child A was discharged from hospital four days later and on was seen at home with Ryan and Lisa on October 19 by HV2. HV2 completed a Family Health Needs Assessment (FHNA) with them but both failed to disclose their history of domestic abuse with previous partners.
- 4.8e.9 On a home visit on 29 October SW1 found Child A asleep on Ryan's lap and no concerns were raised about the three children living in the house. Ryan advised SW1 that he was dyslexic and the inability to, '*get his words out*' led to him being frustrated at times. A referral to an NHS facility run by the district council Mental Health Learning Disability Team (LDT) – was discussed, as were

the potential benefits of a diagnosis of his issues. No decision was made but it was followed up by a telephone call from SW1 a few days later when it is recorded that, *'Ryan welcomes a referral to [the LDT facility] but would like to delay this as he would like to spend some time at home with [Child A] first.'*

- 4.8e.10 On 2 November SW1 spoke to HV2 and told her about Ryan's learning difficulties. There was joint agreement that the KSCS would close their case and this was done on 5 November.
- 4.8e.11 HV2 next saw Ryan and Lisa with Child A at the family home on 6 November and she had no concerns about what she saw. She spoke to Ryan about his learning difficulties including talking to him about considering being assessed by the LDT, although this never took place.
- 4.8e.12 Lisa contacted HV2 on 29 November in order to disengage from the health visitor service. Although HV2 took action in line with guidance in place at the time, Lisa did not re-engage. SW1 and the family GP were made aware of the disengagement. There is a record that in September 2010 the family were seen by another health visitor (HV3), who did not report any concerns. The reason for that contact is not recorded.
- 4.8e.13 On 16 June 2011 the Child B was born. On 5 July HV4 visited the family, reporting that they appeared to be happy and enjoying family life although she advised Ryan and Lisa about the risk of having four large dogs in the house. She also updated the FHNA but did not ask Lisa the question about domestic abuse because Ryan was present. She did give Lisa a booklet that included information to signpost victims of domestic abuse to help and support.
- 4.8e.14 When HV4 visited the family home on 1 August, Ryan became abusive and agitated to the extent that she decided not to continue her visit. His anger was such that it was unclear what it was about. HV4 visited again on 10 August, having sought advice and support from her supervisor (HV5). On this occasion Ryan was calm and apologised for his behaviour during her previous visit.
- 4.8e.15 On the next visit by HV4 on 29 September, Ryan again displayed concerning behaviour. He commented on a television programme that was about the army, and said that if they called for him to join he would line them all up and point a gun at the officers. He demonstrated this as if doing it, saying, *'...no they would not want me bang, bang right through their heads.'* HV4 reported this to HV5, who advised her to contact Social Services about it. Whether HV4 made this contact at the time is not recorded but she did mention the incident when she attended a Strategy Meeting held by KSCS on December 2, about two months later. Apart from being present at meetings that he attended this was the last time that KCHT recorded involvement with Ryan.
- 4.8e.16 KSCS next had contact with Ryan on 29 November 2011, two years after the previous case was closed and less than six months before he killed his mother. This stemmed from an incident in which Lisa's Child D suffered a serious eye injury, which she said was caused by a dustpan that she had thrown at one of the dogs accidentally hitting the child. The matter was referred to KSCS as

Child D had missed hospital treatment for the injury rather than because of the incident itself, which took place six weeks before the referral.

- 4.8e.17 All subsequent KSCS involvement with the family until Barbara's death originates from this incident and they responded to it very quickly. SW2 was assigned the case and on the day it was referred, it was agreed that all four children who were living in the family home would move out and be cared for by extended family members under a voluntary care plan. Children A & B (Ryan's natural children) were placed with their MGM, while Children C & D were placed with a maternal aunt. Although an agreement was drawn up about Lisa's contact with the children it was recorded that there was to be, *'No contact with Ryan but this was to be explored.'*
- 4.8e.18 At a Strategy Meeting held on 2 December a decision was taken to hold an Initial Child Protection Conference (ICPC) because of concerns raised including, *'...Mr Prout/Ryan Cole aka Black's attitude and behaviour...'* It was at this meeting that HV4 mentioned Ryan's behaviour during her visit to the family home on 29 September. Three days after the Strategy Meeting, during a family interview with extended family present, SW2 recorded that, *'Lisa was vocal in regard to Ryan not being supportive and how weird his behaviour was.'*
- 4.8e.19 On 6 December a member of the Kent Police Child Abuse Investigation Unit (CAIU1) informed SW2 that both Lisa and Ryan had been interviewed about the injury to Child D. They both gave the same account of how it had happened.
- 4.8e.20 Three days later Lisa was seen alone by SW2. She was more positive about Ryan but, *'...still wishes to move away.'* This is the first record that Lisa wished to live apart from Ryan.
- 4.8e.21 At an ICPC held on 13 December Lisa's maternal aunt, who had care of the Children C & D, *'...raised concerns about Ryan's mental health issues...'* Both she and the MGM said they did not have a good relationship with Ryan, who they described as, *'Not so nice guy [sic].'* They suspected domestic abuse and the maternal aunt subsequently said that she would not supervise visits by Ryan to the children.
- 4.8e.22 On 24 December an anonymous call (identified as being from a friend of Lisa) was made to the Social Services out of hours number, expressing concerns about Lisa suffering domestic abuse at the hands of Ryan. She said that Lisa denied this but she (the caller) had witnessed Ryan losing his temper and said he gave Lisa a black eye several months ago. She suggested that KSCS were not getting the full picture. As the children were not living with Ryan and Lisa, the decision was taken that action after Christmas was appropriate and it was followed up in a telephone call to Lisa by a duty social worker on 29 December. During that call Lisa became angry at the suggestion that she was still in a relationship with Ryan and said that she was still living in the family home because she, *'...has to live somewhere.'*
- 4.8e.23 On 10 January 2012, the case was transferred to SW3. The transfer summary was written on 20 December 2011 and did not contain details relating to the call

from Lisa's friend; neither did it mention a domestic abuse risk or Ryan's behaviour.

- 4.8e.24 A child protection visit was made by SW3 on 16 January to Children A & B '*... in PGM's care.*' This appears to have been a mistake that should have read 'MGM' as their paternal grandmother, Barbara, was not caring for them. The following day Ryan had supervised contact with the children, at which he was described as interacting and caring for them appropriately.
- 4.8e.25 On 17 January a Core Assessment was completed by SW2, who noted that she had seen Ryan shouting at the four dogs which still lived in the family home, which all ran away from him, although neither the children nor Lisa flinched. Lisa felt that he prioritised the dogs over her and the children, and described how he would shout for 10 minutes and then calm down. She disclosed that she had been a victim of domestic abuse in her relationship with the father of Children C & D but SW2 felt that Lisa might have a limited insight in what domestic abuse was.
- 4.8e.26 During this Core Assessment Ryan said that he had had a troubled childhood during which he had been sexually and physically abused. He was not willing to explore this further with SW2 and said that he did not need help.
- 4.8e.27 On 18 January, CAIU1 telephoned SW3 and said that she believed Ryan and Lisa posed a risk to the children. She also said that Child D had, '*...indicated to her that Ryan hurt his eye*' and that she also had concerns about very poor home conditions. Child D had been interviewed by CAIU1 and when asked if his mother had hurt his eye had said, 'No'. When asked if Ryan had done it, Child D nodded. By the time Child D was spoken to, both Ryan and Lisa had been interviewed and had both said that Lisa had thrown the dustpan at a dog but that it had hit Child D. The decision was taken not to reinterview the couple on the basis that they would be likely to repeat their version and that Child D's account alone would not have strengthened the case for a prosecution. A decision not to prosecute Lisa or Ryan was taken by CAIU1's supervisor (CAIU2) in April 2012 based on all the available evidence.
- 4.8e.28 On 19 January Ryan had supervised access to Children A & B, with the level of supervision decreased. It was agreed at a home visit that day that family contact could take place once a week. Lisa said that she and Ryan no longer wanted to stay together although they were still getting along. SW3 noted the poor state of the house including a broken window that a dog jumped through.
- 4.8e.29 On 26 January the children's maternal aunt phoned SW3 and told her that the Children C & D did not want to see Ryan and that, '*...Child C hates the house.*'
- 4.8e.30 SW3 recorded on 1 February that a health visitor, '*...reports all fine*' and, '*...would like to support Lisa more but Ryan does not allow her into the house.*' On a visit by SW3 to the maternal aunt the following day, the latter says she thought, '*...Ryan had mental health issues from what Lisa had told her.*'

- 4.8e.31 On 20 February Lisa phoned SW3 and said that Ryan had been arrested but this was a case of mistaken identity - this was the incident of damage to cars, which there was ultimately insufficient evidence to charge him with. This was followed up with Kent Police who had no safeguarding children concerns related to this arrest.
- 4.8e.32 The following day SW3 supported Lisa at an appointment with the local authority housing department where she completed a housing application. At a meeting with SW3 following the appointment, Lisa said she did not feel comfortable talking in front of Ryan and she referred to his temper.
- 4.8e.33 On 24 February Ryan and Lisa had a family visit with the children supervised by SW3 and told her that they were upset about the current situation (the children being in care).
- 4.8e.34 A Review Child Protection Conference (RCPC) was held on 6 March; it was attended by Ryan and Lisa, and during it he admitted that the family home was not safe due to the dogs. The Kent Police investigation into the injury to Child D was still ongoing and it is recorded that they were adamant that the children remained at risk, although there was no police attendance at the meeting. It was agreed that the supervision of the couple's contact with the children would be decreased. In addition, Ryan and Lisa agreed to attend a parenting programme.
- 4.8e.35 On 12 March SW3 allowed Ryan to take Children A & B out for an hour and he was very grateful for this. He said that he had not gone to the first meeting of the parenting group as he needed to 'sign on' and Lisa gave the same reason for why she had failed to attend. They both went to the second group meeting and it was recorded that they settled in well, shared thoughts and views on the topics discussed, and both appeared to enjoy the group.
- 4.8e.36 On 22 March following contact by the FGC co-ordinator with Barbara Cole, it is recorded that, *'Ryan thinks it is good that his mother can now attend.'* The FGC was held on 27 March and both Barbara and Barry attended. They offered support to facilitate increased access to the children by Ryan.
- 4.8e.37 At a Core Group meeting on 28 March the comments about Ryan and Lisa, and about the children's progress, were all positive. In particular, the health visitor present commented that Ryan was much more engaged with the children and that, *'He had sorted out the finances and the house.'* It was recorded the following day that Ryan and Lisa had missed 3 sessions of the parenting group and due to this they would no longer be able to join it. On the same day Ryan telephoned SW3, upset and swearing, saying he said he did not want to see Lisa or Children A & B again. When SW3 offered to write to him he explained he was dyslexic and could not read. In a call to Lisa made the same day by SW3 Lisa said that Ryan would continue to see the Children A & B. A further call from Ryan that day confirmed that the arrangements in place for him to see them would continue.



- 4.8e.38 On 4 April Ryan telephoned SW3 again and during this call he became very abusive; he was swearing and referring to SW2 in racist terms. He was described as verbally aggressive and threatening, and he terminated the call after refusing to listen to SW3. The following day Ryan telephoned SW3 twice; he was very agitated and made vague general threats.
- 4.8e.39 On 30 April, a Core Group meeting was held, which Lisa and Ryan attended, as did Barbara and Barry. There is no record of how Ryan behaved in the meeting.
- 4.8e.40 On 15 May, SW3 visited the family home for the final time and the couple showed her around the house, which was in good condition. The plan was for Lisa and Barbara to monitor the condition of the house and Ryan went on to say that, '*... [Barbara] was not his birth mother as his mother and father were too old to have them*'. The couple were described as well and fairly positive, although he did get agitated at one point asking, '*...how long [KSCS] still want to keep the children with family members.*'
- 4.8e.41 On 17 May, SW3 had the last KSCS contact with Ryan prior to him killing his mother, when she telephoned him and said that following her visit she felt the family home was safe for Child A & B to visit. He told her that Lisa's new house was available and she was ready to move, although she was still living in the family home when he killed Barbara.

#### 4.8f *Housing*

- 4.8f.1 At the time he killed his mother, Ryan was the tenant of the house referred to in this report as the family home. The landlord was AMT (SE) Ltd, an established letting and property management company whose local office was in Town D, a few miles from Town A.
- 4.8f.2 Although enquires made with the landlord through East Kent Services (EKS), who manage housing services for three councils in East Kent, do not add anything relevant to the death of Barbara, they revealed that AMT's staff had refused to continue visiting the premises due to Ryan's behaviour towards them. EKS were unaware of this until they made enquiries for this review and they had not experienced any issues or problems with Ryan's housing benefit claim. The enquiry also revealed that Ryan had built up debts owed to the landlord dating back to 2009 when he moved into the house.
- 4.8f.3 Subsequent to Ryan's arrest the landlord obtained a court order and took possession of the house. This report does not analyse Ryan's contact with of AMT or EKS further as it is not relevant to the terms of reference.

*4.8g Kent Fire & Rescue Service (KFRS)*

4.8g.1 KFRS went the family home twice. On 13 November 2010 they attended an incident where there was arcing in the fusebox but there was no significant damage. The following day they made a home safety visit of which there are no details. Their records show the householder has either Paul Black or Simon Black but this would almost certainly have been Ryan as he was using the surname Black at this time. Neither attendance is relevant to the terms of reference of this review.

## 5. Analysis

### 5.1 Introduction

5.1.1 In this section the contacts that Barbara and Ryan had with agencies are examined, based on the recorded facts set out in the previous section. The analysis is done by reference to each individual agency.

### 5.2 Agency Involvement – Barbara Cole

#### 5.2a *Surgery 2, Town A*

5.2a.1 The symptoms that Barbara presented with when she visited her GP were not indicative of domestic abuse and she did not exhibit any other signs that she was a victim. Her medical records dating back to 1993 raise no concerns that she was a victim of domestic abuse.

5.2a.2 Surgery 2 does not have policies and procedures for dealing with domestic abuse (victims or perpetrators) and although it would be good practice to have these in place, it is unlikely that they would have been triggered in Barbara's case.

#### 5.2b *Kent Community Healthcare NHS Trust*

5.2b.1 As with the visits to her GP, on the occasions when she dealt with KCHT there were no indications that she was a domestic abuse victim. KCHT have policies for dealing with victims of domestic abuse and have a Domestic Abuse Lead. In addition, there are trigger questions on the Symphony client care software used by KCHT (and more widely in the NHS) relating to Safeguarding Vulnerable Adults, although the nursing sister who dealt with Barbara at the Minor Injury Centre was unaware of these. Whilst in Barbara's case this was not an issue, KCHT should ensure that all clinical staff know about the policy and the trigger questions and this is subject to a recommendation. (**Recommendation 1**)

#### 5.2c *Kent County Council Specialist Childrens Services (KSCS)*

5.2c.1 Barbara was seen once in her home by a KSCS FGC co-ordinator to assess its suitability as a place for Ryan's access to his children. It is not clear whether she was alone when she was seen but there is no record that there were any concerns arising from the visit.

5.2c.2 Barbara's other contacts with KSCS were in meetings, also to discuss ways in which Ryan's contact with his children could be better facilitated. One of the concerns was whether the family home (that Lisa was soon to move out of with the children, leaving Ryan there alone) was safe for his Children A & B to visit and the record of the first meeting shows that Barbara offered Ryan practical support to improve the house. Although KSCS staff had experienced Ryan's erratic behaviour and mood swings, and were aware of the fact that he might be

a current domestic abuse perpetrator, they had no indication that he was likely to direct violence towards Barbara.

#### *5.2d Mention of Barbara Cole to Agencies*

- 5.2d.1 The two occasions when Ryan mentioned to professionals (both doctors) that he was angry with Barbara were over four years apart and the last was two years before he killed her. Whilst with hindsight it would be easy to attribute significant weight to these comments, they were heard in the context of a patient with known anger issues which he attributed to a number of factors over several years.
- 5.2d.2 The reasons he cited for being angry with his mother were different on each occasion: the first because he believed that she had had an abortion and deprived him of a sibling; the second because she failed to support him when he was abused as a child. On neither occasion did he threaten to harm her and the doctors cannot reasonably be criticised for taking no further action about these specific comments. In between these two references to being angry with his mother, Ryan made a positive comment about her to his PSO, saying that he had a reasonable relationship with her, when referring to his move back to Kent.
- 5.2d.3 He mentioned Barbara on two other occasions, both within two months of killing her. The first was a positive and made to the FGC co-ordinator to whom he said that he thought it was good that she could attend the conference. In the second, made to a social worker, he said that Barbara was not his birth mother as his parents were too old to have children. This was demonstrably not the case as Barbara was 19 years old when he was born.

#### *5.2e Summary*

- 5.2e.1 When agencies had contact with Barbara, she was treated appropriately and staff who dealt with her had no cause to believe she was or was likely to be a victim of domestic abuse. There are recommendations arising from this section but they are not specific to this case, and if implemented at the time would not have reduced the likelihood of Barbara being killed by Ryan.
- 5.2e.2 Two of the comments made to professionals by Ryan about Barbara were positive, one was neutral (although obviously incorrect) and in two he expressed anger towards her. Taken individually neither of the latter was threatening nor did he suggest that that he would use violence against her. Even taken together, amongst the contact that Ryan had with agencies in the years leading up to killing his mother, the comments could not reasonably have been seen as precursors to such a serious event.
- 5.2e.3 Barbara was never the subject of a Multi-Agency Risk Assessment Conference (MARAC). There is no reason why she would have been because she never made a report that she was a victim of domestic abuse, nor did any agency have evidence or information that she was.

### 5.3 Agency Involvement – Ryan Cole

#### 5.3a *Kent Police*

- 5.3a.1 Kent Police dealt with Ryan as a victim and an offender prior to August 2002 when he left Kent, and again following his return from Sussex. This analysis considers cases of domestic abuse and other violence, including harassment, in which Ryan was a victim or perpetrator. It also examines the allegations of physical and sexual abuse that he made to professionals from other agencies.
- 5.3a.2 The complaint of rape made against Ryan in 2000 should have been recorded as a crime and fully investigated. The relationship between Ryan and the victim at the time and their young ages do not justify the failure to do this. Thirteen years have passed since the complaint was made and there have been significant developments in the crime recording during that period. All complaints of rape are now recorded as crimes and each is fully investigated. Kent Police should consider whether to record this complaint as a crime and if so whether to open an investigation. If the decision is not to do so, a clear rationale for this should be recorded. (**Recommendation 2**)
- 5.3a.3 The complaint made in 2001 to Kent Social Services about the injury to Child F was rightly referred to Kent Police, who investigated it. The medical evidence was inconclusive, there was no consistency in the explanation of his injury and the cause of them was not established. The decision to close the case was appropriate.
- 5.3a.4 Ryan received a harassment warning in 2002 in relation to threatening telephone calls made to his ex-wife Louise Cole. Later that year he received a caution for damaging her mobile phone. Posting the remains of it through her letterbox with a note that could have been construed as amounting to further evidence of the harassment could have led to a prosecution following the warning he had received earlier in the year. However, the decision to caution rather than seek to prosecute was taken over ten years ago and there may have been unrecorded reasons for it.
- 5.3a.5 Ryan made a further telephone threat to Louise, also in 2002, and he included Child E in the threat. He was not traced and arrested until 9 months later when he denied that he had threatened to kill Louise. It would have been difficult to meet the charging standard for the crime of 'threats to kill' without an admission, given that there was no record of the call or corroboration of the threat. However, rather than take no further action, Kent Police cautioned Ryan for an offence contrary to the Section 43 1(A) of the Telecommunications Act 1984 – effectively sending a call of a menacing nature - on the basis that he admitted threatening to seriously assault Louise. This was an appropriate course of action.

- 5.3a.6 Following his return to Town A in late 2007, the first two contacts with Kent Police came when Ryan was the victim of assaults, both of which took place in November 2008.
- 5.3a.7 The incident that led to him being issued with a harassment warning in September 2009 for threatening and verbally abusing Brett Taylor was correctly identified as domestic incident because of the previous relationship between Lisa and Brett. It would not have fitted the definition had she not been involved. The officer completing the risk assessment did not identify any mental health issues, probably because Ryan was not overtly displaying any. The SPECSS risk assessment used by Kent Police at the time has now been superseded by the Domestic Abuse, Stalking and Honour Based Violence (DASH) model, which is almost universally used by agencies dealing with actual and potential domestic abuse victims.
- 5.3a.8 In October 2011 Ryan was arrested and cautioned for hitting a man with a wooden stick, causing him minor injury. The use of a weapon could be considered as an escalation of his violent behaviour but it was a minor assault that was not part of a continuing series of violent incidents in which Ryan was the perpetrator, and it was the only time since returning to Kent that he was known to have assaulted anyone.
- 5.3a.9 As described in paragraph 4.8e.27 above, on 18 January 2012 CAIU1 telephoned SW3 and told her that Child D had indicated that Ryan had hurt his (Child D's) eye. This is the only record suggesting that Ryan might have been the offender and neither he nor Lisa was reinterviewed for the reasons set out in that paragraph. This decision was a professional judgement made by CAIU2, an experienced supervisory specialist child abuse investigator. With hindsight it may have better to have interviewed Child D before Ryan and Lisa or, having interviewed them first as was the case, to have reinterviewed them following Child D contradicting their version. Had either of them, or both, had altered their version of events or corroborated Child D, the case would probably have been passed to CPS for a prosecution decision. In the event, in April 2012, CAIU2 made the decision that there was insufficient evidence to prosecute and the case was filed. CAIU2 has accepted that he could have made a fuller note regarding his decision not to reinterview and no recommendation is made regarding this.
- 5.3a.10 Having examined Ryan's dealing with Kent Police prior to him killing Barbara, there remains his disclosures that he was the subject of physical and/or sexual abuse. He made a total of 10 complaints, which were recorded by professionals between November 2005 and January 2012. Eight of these were to doctors and he made one each to a Probation Service Officer and a Social Worker. He may have made similar disclosures on other occasions to other agencies that were not recorded, in which case those professionals who did at least make a record could be viewed in a more favourable light than those who did not. This lack of referral in cases where it is known an allegation was made is examined under the analysis of each agency's involvement with Ryan.

5.3a.11 The first time that Kent Police knew of Ryan's allegation that he was the victim of childhood abuse committed by his father was after his arrest for killing Barbara. While in police custody, he was spoken to by a Forensic Liaison Nurse (FLN) from Kent Forensic Psychiatric Service as part of the process to decide whether he was fit to be interviewed by the police. In a statement made afterwards she wrote:

*'He (Ryan Cole) stated that he had been subject to serious and systematic childhood sexual and physical abuse by his father, which included a paedophile ring and I concluded these self-reported childhood experiences to be contributory factors for mood and behaviour prior to and during detention'.*

5.3a.12 In their IMR response it is noted by Kent Police that:

*During this assessment Ryan made reference to wishing to kill his father.*

5.3a.13 Ryan was charged with the murder of Barbara without being interviewed by the police because he was deemed by the FLN as unfit to be interviewed. There was a dispute between the police and the FLN about her competence to make this decision. This is outside the terms of reference of the DHR but a separate review has been carried out arising from this case and its recommendations have been implemented.

5.3a.14 In respect of Ryan's allegation to the FLN, Kent Police have said:

*The comment was made during a medical consultation and has not been treated as a formal allegation of crime by Ryan Cole. Kent Police treat all complaints of sexual and physical abuse seriously. Kent Police will review the circumstances of this complaint in the light of information of a similar nature, which Ryan Cole has disclosed to other agencies.*

5.3a.15 As a result of this review Kent Police are aware of the abuse allegations made by Ryan to professionals from other agencies over a period of six years, in addition to the one that was made while he was in their custody following his arrest for killing his mother. They have approached Ryan's solicitor and the doctor in charge of his case at the secure hospital where he is currently detained. Neither believes it would be appropriate to interview him about these allegations at present. In addition, when referring to Ryan's delusions at his criminal trial, the prosecutor stated that 'Long before the events of the 20<sup>th</sup> of May of this year he was telling friends that both of his parents had farmed him out to paedophiles who had repeatedly raped him. That did not happen, and he now realises that it never did happen'.

5.3a.16 In summary, none of the recorded involvement that Kent Police had with Ryan prior to him killing Barbara could have led them to anticipate that he was likely to use violence against her. They knew he was a domestic abuse perpetrator but not at a level or with a frequency that would cause him to be assessed as a

person who presented high risk of causing serious harm. There is no evidence that the level of abuse he committed escalated and Kent Police did not attend any incidents where he used physical violence in a domestic setting. Although other agencies refer to concerns about Lisa Prout being the victim of domestic abuse by Ryan, these were not reported to Kent Police.

### *5.3b Sussex Police*

- 5.3b.1 Ryan's involvement with Sussex Police centres on two issues: the harassment by him and Julie Black of his ex-girlfriend Louise Harris, and his relationship with Julie.
- 5.3b.2 Sussex Police dealt with the couple's harassment of Louise Harris positively. Both were prosecuted and convicted; Ryan receiving a 12 month Community Order.
- 5.3b.3 When police officers attended disturbances caused by Ryan and Julie, they usually gave words of advice but where substantive offences were disclosed, one or both was arrested. In each case the victim subsequently withdrew their complaint and there was no prosecution. Whilst serious assaults can sometimes be prosecuted successfully without the victim's consent, this is much less likely in cases where the injury is minor or not visible.
- 5.3b.4 In the majority of domestic abuse incidents between cohabiting adults of opposite sexes, the woman is the victim. The record of police attendance at incidents involving Ryan and Julie shows them being a victim and perpetrator in a ratio that is close to even. The level of abuse and violence that they inflicted on each other did not escalate significantly during the relationship and it is difficult to judge in hindsight which of the two, if either, was the overall instigator.
- 5.3b.5 Sussex Police attempted on three occasions to carry out a domestic abuse risk assessment of Julie using the process in place at the time, and although on two occasions the risk was graded, it is difficult to see what these grades were based on as she refused to engage. No risk assessment was carried out on Ryan as a victim but Sussex Police now use the DASH risk assessment for all incidents of domestic abuse, which should ensure one is carried out with all victims in appropriate cases.
- 5.3b.6 Sussex Police could have involved other agencies, such as the couple's landlord or domestic abuse support agencies, in addressing the problems caused by the volatile relationship between Ryan and Julie. If this was considered or done it was not recorded.
- 5.3b.7 In summary, Sussex Police dealt with incidents involving Ryan in a positive way, although a multi-agency approach may have helped to address the ongoing domestic abuse between him and Julie, and the anti-social behaviour experienced by their neighbours. Sussex Police now have a Neighbourhood Policing Strategy and supporting structure and it is more likely that such an approach would now be applied to a similar situation.



### 5.3c *The Surgery 1, Town B*

- 5.3c.1 The only information that Surgery 1 can provide directly are the dates between which Ryan was registered with them. The inability to retrieve his computerised medical records means that it is not known what consultations he had with doctors there other than those that resulted in a referral to secondary mental health services. Although this has been referred to the Medical Director of NHS Sussex, a recommendation is made. (**Recommendation 3**)
- 5.3c.2 In the first referral made by GP1 to SPT (HCMHT) he states Ryan disclosed that he was hitting his partner, smoking cannabis, and that he had a history as a victim of sexual and physical abuse. On the basis that GP2, who also referred him to HCMHT at a later date, would have read Ryan's notes, he would also have been aware of these issues.
- 5.3c.3 In summary, the absence of Ryan's medical records make it impossible to confirm whether or not his disclosures about the domestic abuse of his partner, or of being a victim of abuse himself were shared with any other agencies apart from secondary mental health services. The agencies that this information was likely to have been shared with have contributed to this review, so on the balance of probabilities it was not. Recommendations about actions taken by health professionals when a patient discloses being the victim of historical child abuse or being a domestic abuse perpetrator cover these issues.  
(**Recommendations 4 & 5**)

### 5.3d *Sussex Partnership NHS Trust (SPT)*

- 5.3d.1 SPT records show that Ryan was referred to HCMHT three times by two GPs from Surgery 1 in the period from October 2005 to June 2007 and he was seen four psychiatrists, including a consultant, as well as by at least three CPNs.
- 5.3d.2 There are significant concerns about Ryan's involvement with SPT; specifically HCMHT:
- There is no evidence of staff making contact with adult or childrens services following his disclosure that he was hitting his girlfriend. Guidance in place at the time should have ensured this happened.
  - The psychiatrist who saw Ryan when he presented at A&E carried out a risk assessment that identified he was a risk to himself or others but there is no evidence of a management plan to follow that up when it was received by HCMHT.
  - In a consultation with a psychiatrist Ryan said that he thought his estranged wife was abusing Child E and that he was going to report this to social services. There is no evidence that the psychiatrist disclosed this to Social Services.
  - There is no record that his disclosure about being a victim of abuse, which was made to two psychiatrists on separate occasions, was reported to any other agency.

- Plans by a psychiatrist to support Ryan by referring him to Addaction and chasing up the council about getting him house were not followed through.
- There is no evidence that social services were contacted to check whether they were aware that Ryan, who had admitted being a domestic abuse perpetrator, was having regular contact with Child E and if so, whether it was being managed.
- The Occupational Therapist who facilitated anger management sessions that Ryan attended either failed to provide feedback to the referrer or if she did provide feedback she failed to record it. Good practice would have been to confirm his level of attendance and the progress he made.

5.3d.3 In summary, taken together, these issues indicate that there was a lack of understanding by SPT psychiatrists that in cases where a patient discloses that he or she is committing or is likely to commit domestic abuse, the focus on the patient's safety and wellbeing should extend to those who are or who may become their victims. In this case there is no record or evidence that the disclosures that Ryan made to doctors were further explored with him or that they were shared outside the medical profession. Sharing such disclosures appropriately, either by direct referral, or through established multi-agency fora where these exist, is essential both for the investigation of historical abuse and for the protection of current and future potential victims.

### 5.3e *Surgery 2, Town A*

5.3e.1 Ryan visited Surgery 2 four times; once in 2008 and three times in 2010. On each occasion the visit was in relation to his mental health problems and in 2010 he told whichever GP he saw when he attended an appointment that he was the victim of child abuse. This was recorded in the GPs' notes but there is no record that it was explored further.

5.3e.2 Both GP3 and GP4 referred Ryan to KMPT mental health services and the action taken following those referrals is analysed section 5.3f below.

5.3e.3 In summary, it is right that GPs refer patients who present with significant mental health issues to secondary mental health services for the specialist treatment that they need and this was done on each occasion Ryan was seen at Surgery 2. However, despite the GP recording a reference to abuse on all three visits in 2010, KMPT records show that this information was only passed on to them on one occasion; following his visit to GP4.

### 5.3f *Kent & Medway Social & Care NHS Trust (KMPT)*

5.3f.1 Ryan first had contact with KMPT in October 2008 when he spoke to CPN1 on the telephone during a call made to them by his partner, and he was advised to register with a GP in order to access KMPT services. This he did (at Surgery 2) and GP3 referred him to KMPT. Following that referral he was not seen or spoken to by KMPT, who sent him letters trying to arrange an appointment. He

did not attend appointments or respond to the letters and he was discharged back to GP3 about 6 weeks later.

- 5.3f.2 It is significant that KMPT did not receive Ryan's notes from SPT (HCMHT), which contained a diagnosis of his mental health condition and the treatment that he had received for it. One recorded attempt was made to get these by fax request, and it may have been because it was shortly before his discharge back to his GP that it was not followed up. Had KMPT received the notes and examined them they would also have seen that he was illiterate and may have reconsidered the use of letters as a means of contacting him.
- 5.3f.3 On 10 May 2010, 18 months after the discharge back to GP3, KMPT received two further referrals from Surgery 2: one each from GP3 and GP4. These were screened and Ryan was sent an appointment by letter. Despite noting in the screening process that he was known to HCMHT, there is no record of a further request for his records.
- 5.3f.4 After Ryan visited GP3 again in June 2010 she re-referred him to KMPT because he told her that appointment letters were being sent to the wrong address; probably because he had not told the surgery that he had moved in 2009. CPNs did then speak to Ryan by telephone; the conversations being confined to trying to arrange appointments. He did not turn up for any of these and at the end of July 2010 he said he no longer required their services. He was discharged back to GP3 and was not seen again before he killed Barbara.
- 5.3f.5 Ryan was never seen or treated by KMPT staff. In 2008 the reasons could have included him deliberately failing to respond to letters, not receiving them or not being able to read them due to his illiteracy. In 2010 it was because initially the letters were sent to the wrong address but subsequently he failed to turn up for appointments made by telephone and then said that he no longer required mental health services.
- 5.3f.6 Unlike those with physical conditions, patients with mental health issues can be compelled to engage with mental health services in certain circumstances. The Mental Health Act 1983 (as amended by the Mental Health Act 2007) provides for compulsory admission to hospital and/or treatment. A detailed description of the powers provided under the Act is outside the scope of this review and it is sufficient to say that the conditions that need to be met in order to invoke these powers did not apply to Ryan prior to him killing his Barbara. The fact that he failed to engage left KMPT with little alternative other than to discharge him.
- 5.3f.7 The issue is whether the efforts they made to engage Ryan were reasonable. There was a process in place, which involved sending of letters with appointment dates and options to call if these were not suitable. It was not the fault of KMPT that at one stage they were sending letters to the wrong address and, in the absence of his medical notes from HCMHT, they did not know that he was illiterate. In 2010 they also used telephone calls after a time and he still failed to attend appointments.

5.3f.8 In summary, KMPT did what they reasonably could to engage Ryan but they never actually saw him. They knew that he had a history of treatment by HCMHT but failed to ensure that they obtained his notes, which would have included the diagnosis and could have been helpful in understanding his condition. Although having possession of these would probably not have resulted in any increased engagement with Ryan, this review makes a recommendation about following up requests to other agencies for medical records. (**Recommendation 6**)

### 5.3g *Surrey & Sussex Probation Trust*

5.3g.1 In the main, Ryan complied with the requirements of his Community Order while he was in Sussex and when he missed appointments he produced satisfactory evidence to support his reasons for absence. He disclosed being a victim of childhood physical abuse at the hands of his father at his first probation assessment and that he was being treated for mental illness. There is no record of action being taken or advice given.

5.3g.2 The failure by the SSPT Probation Officer (PO) to conduct a Spousal Abuse Risk Assessment (SARA) at the pre-sentence report stage in a case that involved domestic abuse was not identified by a supervisor. SARA completion is now a more integral part of the assessment process when domestic abuse is identified because the OASys offender management software does not allow the person completing the assessment record to move on through the process without completing a SARA in such cases.

5.3g.3 Ryan told PSO1 that he wanted to resume contact with Child E in Kent and despite the fact that his Community Order related to a domestic abuse offence, details of Child E (name, date of birth and address) were not obtained from Ryan. This would have been a reasonable expectation so that information could be passed to Kent Social Services for the relevant checks to be undertaken.

5.3g.4 There is no record that the contradictory addresses that Ryan claimed to be moving to in Kent were checked, or that the address he settled on (his parents') was confirmed or assessed for suitability.

5.3g.5 At the time, Probation Circular (PC) 25/2007 provided guidance on case transfers from one petty sessional area to another. It required the transferring probation trust to request, from the receiving trust, an assessment of the suitability of the address given by the client within 5 working days. Although the address was shared (not within 5 working days), there is no record that SSPT specifically requested an assessment of it. This is particularly relevant in domestic abuse cases such as Ryan's but SSPT took his word that he was going to live at his parents' address and that it was suitable.

5.3g.6 PC 25/2007 has been replaced by Probation Instruction 17/2010, in which an appendix contains a checklist of actions required on case transfer, including an address check. This should reduce the likelihood of cases being transferred without the address being confirmed or assessed and for this reason it is not

subject of a specific recommendation. The fact that it should have been identified by the PO's supervisor, as should the failure to complete a SARA, gives rise to a recommendation. (**Recommendation 7**)

### *5.3h Kent Probation Trust (KPT)*

- 5.3h.1 When Ryan first met PSO2 in Kent he confirmed that he had been living at his parents' address for 10 weeks, during which time he had continued to report to SSPT. Again, it appears that he was taken at his word and no enquiries were made to establish whether he was living there and if so whether it was suitable.
- 5.3h.2 When Ryan's case was transferred to KPT, they should have reviewed the information on OASys and also the SARA. Had this been done it would have been clear that a SARA had not been completed.
- 5.3h.3 In contrast to his failure to attend appointments with mental health services, Ryan complied with the terms of his Community Order in Kent and he received appropriate support throughout it.
- 5.3h.4 As with SSPT, the failure by the PSO's supervisor to identify omissions is subject of a recommendation. (**Recommendation 7**)

### *5.3i Kent Community Health NHS Trust (KCHT)*

- 5.3i.1 KCHT health visiting team first had contact with Ryan following the birth Child A in September 2009 when they conducted a joint visit with KSCS following his threat to remove her from the NICU. There were a further three recorded visits, including one during which a Family Health Needs Assessment was conducted. No further concerns were raised about Ryan's behaviour at any of the visits. Lisa disengaged from the health visitor service less than two months after Child A was released from hospital but there is no evidence that Ryan had a part in this decision.
- 5.3i.2 A series of visits made to the family home by HV4 following the birth of Child B in June 2011 evidenced Ryan's changeable personality. Although there were no specific concerns about the children, on the last visit in September 2011 he made some disturbing comments about shooting people. HV4 sought advice from her preceptor (HV5), about this and was advised to contact Social Services. HV4 cannot recall whether she did this and HV5 did not check to confirm it had been done: the fact that KSCS have no record of it suggests it had not. However, HV4 did raise the issue in a multi-agency strategy meeting held in December and it was recorded.
- 5.3i.3 No further visits by health visitors to the family home were recorded by KCHT because following the incident on 29 September that resulted in Child D suffering an eye injury, Children A & B were living with their MGM. KSCS

records do indicate a subsequent contact between a health visitor and Ryan but it is not clear where this took place.

- 5.3i.4 There is a recommendation for KCHT about the need for supervisors to ensure that their instructions and advice are heeded and followed by their staff.  
**(Recommendation 7)**

*5.3j Kent County Council Specialist Childrens Services (KSCS)*

- 5.3j1 Ryan first had contact with KSCS in September 2008 when he was living with Lisa Prout and Children C & D. This was as a result of a complaint from the children's paternal grandfather about drug dealing taking place. Following a home visit when Ryan was present, no concerns were raised and the case was closed. Lisa's separation from the father of Children C & D, Brett Taylor, was acrimonious and this complaint from their paternal grandfather could have been motivated by spite. However, where social services departments receive information that drug dealing is taking place at an address they have involvement with, particularly one where children are living, they should refer this to the police. **(Recommendation 8)**
- 5.3j.2 A child protection enquiry under Section 47 of the Childrens Act 1989 enquiry took place following Child D suffering an injury at nursery school July 2009. Ryan went to the nursery a few days after the incident, when he became angry and aggressive towards the manager. Although he had a history of anger, other parents without such a history might have behaved similarly if they believed their child's account that he had been pushed by a teacher.
- 5.3j.3 Following closure of the S.47 enquiry, it was over 18 months until KSCS next had involvement with the children or Ryan, when in November 2011 Child D suffered the eye injury. All further KSCS involvement up until Barbara's death less than six months later stemmed from this incident. The four children living with Lisa and Ryan were placed on a voluntary care plan on the day KSCS were made aware of the incident and removed from the family home to live with relatives. A police investigation into how Child D's injury was caused was also conducted. This is a good example of agencies acting promptly, sharing information and working together.
- 5.3j.4 During the period following the children's removal, KSCS's aim was to rehabilitate the children, primarily with Lisa, who was taking active steps to move out of the family home. The children would have gone to live with her, and Ryan would have been permitted to have access to them at the family home, which he intended to remain in, subject to its condition being improved. This plan seemed to be progressing, with Barbara offering to help Ryan to do this.
- 5.3j.5 There does appear to have been some over optimism by professionals about the family's situation. This is exemplified by the record of the Core Group meeting held on 28 March 2012 from which all of the comments recorded are

positive. Whilst there is evidence of progress in some areas at that time, such as the FGC process, both before and after the meeting was held there were issues recorded which raised significant concerns.

- 5.3j.6 In the period from Child D's injury through to Barbara's death, when KSCS in particular had a lot of contact with Ryan, he displayed anger and frustration on a number of occasions. In the context of a man with learning difficulties who saw his children taken away from him because of an incident that there is little evidence he was responsible for, this does not seem unreasonable and would not necessarily have given rise to serious concerns.
- 5.3j.7 KSCS staff had concerns that Lisa was a victim of domestic abuse and this was corroborated by the call made anonymously to them by her friend. The fact that health visitors found it difficult to speak to her without Ryan being present was further grounds for suspecting this. Lisa did not make any disclosures and although she may have been fearful of doing this, at the time Ryan killed Barbara, she was about to leave him and set up home with the children and there is no evidence that he actively tried to prevent this.
- 5.3j.8 The transfer summary covering the handover of the case from SW2 to SW3 was deficient in that it failed to mention possible domestic abuse and Ryan's behaviour. As well as being a factor in the protection of the children, the latter was relevant to safety of the staff dealing with him. In addition, information that was received after the summary was written but before the handover was completed was not included. A recommendation is made about the need for transfer summaries to include all relevant up to date information.  
**(Recommendation 9)**

### 5.3k *Summary*

- 5.3k.1 The facts and analysis of Ryan's involvement with agencies are lengthy and may appear to tell a story of a man who was constantly involved with multiple agencies but the chronology of contact with him does not support this. In particular, it does not suggest that he was coming into contact with agencies more frequently as time went on. It was the single incident of the injury to Child D's eye, for which there is little evidence that Ryan was responsible, that led to nearly all of his contact with statutory agencies in the 18 months prior to Barbara's death.
- 5.3k.2 In 2005/6 when Ryan was in Sussex and living with Louise Black, his engagement with Sussex Police was frequent. He also had significant contact with SPT during this period, having been referred following visits to Surgery 1. It may have been that he realised his mental health was a factor in the lifestyle he was leading and was seeking help. Following his arrest for harassment in October 2006 his contact with Sussex Police as an offender stopped completely, which might indicate that he was responsive to positive action. He received a Community Order in July 2007 and almost immediately tried to engage with health services again. When he returned to Kent he had no contact with any agency for the period of his Community Order. Shortly after

completing it he had contact with Surgery 2 and was referred to KMPT for the first time. The only further contact he had with health services about himself was with Surgery 2 and KMPT for a second spell in 2010. His contact with Kent Police was neither regular nor frequent before he killed Barbara.

- 5.3k.3 The contact that Ryan had with KCHT health visitors and KSCS was not in his own right, but the impact of that period may have been significant given that his children were taken from him, he was separating from their mother and he was facing eviction. The extent to which that added pressure contributed to him killing Barbara cannot be judged with any certainty.
- 5.3k.4 During his spasmodic contact with agencies he disclosed that he was a victim of childhood abuse to a number of professionals, predominantly in health service agencies. Only one agency - KSCS – records any attempt to explore that and this was rebuffed. Other agencies appear to have ignored it.
- 5.3k.5 There were indications about the complex relationship that Ryan had with his mother which, with hindsight, might provide an insight into what led him to kill her. His comments about his belief that she had had an abortion, that she did not support him during the period when he said he was being abused and the fact that she was not his birth mother are juxtaposed with his reliance on her to support his increased access to his children. Equally, his disclosures about being a victim of child abuse committed by his father take on greater significance when viewed together and in the light of the tragic incident in May 2012.

#### **5.4 Analysis of Multi-Service and Multi-Agency Working**

- 5.4.1 Before examining if services and agencies shared information and worked together effectively in this case it is appropriate to consider the statutory formal process for identifying potentially dangerous offenders - Multi-Agency Public Protection Arrangements (MAPPA) - and whether Ryan should have been subject to this. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.
- 5.4.2 Given his offending history, Ryan did not fit the criteria to be classified as a MAPPA Category 1 or 2 offender but he could have been assessed as a Category 3 offender:

*Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm **and** which requires multi-agency management. This might not be for an offence under Schedule 15 of the Criminal Justice Act 2003.*

- 5.4.3 Had all the evidence and information that has been examined in this report been brought together at any time before he killed Barbara, it is highly unlikely that Ryan would have met the criteria necessary to be registered as a Category 3 offender because he would not have been assessed as 'dangerous'.



- 5.4.4 If every person with a similar combination of offending history and mental health diagnosis to Ryan fell into the MAPPa process there would be insufficient resources to manage it effectively. It is about identifying offenders, including domestic abuse perpetrators, who present a clear and present danger to an individual or the public and, although hard to quantify, it is probably that it has prevented many serious assaults and murders. The fact that Ryan was not a registered MAPPa offender is not an indication that the process does not work.
- 5.4.5 Both the main areas of multi-service working in relation to Ryan involved KSCS. KCHT health visiting team and KSCS worked together in respect of the children and this involved contact with him. KSCS referred Child D's eye injury to Kent Police and were kept up to date with significant developments in the investigation. Multi-agency working relating to individuals will apply most in cases where the risk to the person or that posed by them is greatest and that is right. Ryan was not apparently at the high end of either scale, and agencies tended to manage their dealings with him within their own resources.
- 5.4.6 The two areas where there should have been more consideration given to sharing information related to Ryan as a domestic abuse perpetrator and as an alleged child abuse victim.

## 6. Conclusions

6.1 **Conclusion:** - *There is no evidence or information that Barbara Cole had been a victim of domestic abuse prior to her death.*

6.2 **Conclusion:** - *No agency could reasonably have foreseen Ryan Cole's potential to kill his mother or anyone else.*

6.2.1 A number of facts were clear to one or more agencies from their dealings with Ryan. He:

- had learning difficulties;
- was illiterate;
- had mental health issues that manifested themselves in anger and self-harm;
- was a cannabis user;
- had been involved in domestic abuse, both as a perpetrator and a victim; and
- he disclosed that he had been a victim of historical physical and/or sexual abuse.

6.2.2 The agencies that dealt with Ryan come into contact on a regular basis with people who meet some, most or all of these criteria. Their reaction and response must be risk based and he was at the lower end of risk both in terms of the frequency and level of violence he used, and the effects that the mental illness he suffered caused him to exhibit to the agencies dealing with him.

6.2.3 On the basis of what agencies contributing to this review experienced, Ryan was not becoming progressively more violent or using violence more regularly. He was not seen in his own right by any health agency for almost two years prior to him killing Barbara, so it is not possible to give a clinical view of whether his mental health deteriorated significantly in that period.

6.2.4 The agency that had the most contact with him during the months leading up to him killing Barbara was KSCS. He displayed anger on occasions when dealing with them but at other times he did not. He was a parent whose children had been removed from the family home and he had to make positive efforts to ensure that his access to them was maintained. In addition, his partner, the mother of two of his children, was leaving him and setting up a new home with the children, and he was also in arrears with rent on the family home and facing eviction. It is therefore not surprising that he exhibited anger and frustration at times and this might have reasonably been expected of anyone in his circumstances, regardless of whether or not they had clinical anger management issues.

- 6.2.5 Agencies have insufficient resources to monitor all the people that they have contact with and who display mental illness and violence at the level Ryan did. Risk assessments must be evidence based and managed according to those assessed as posing the highest threat. Ryan was offered mental health services, which he took up on some occasions but did not on others.
- 6.2.6 There will be occasions when murders are committed that could not have been reasonably anticipated. This is will be rarer in cases of domestic homicide than when the victim and perpetrator are strangers to each other, but the killing of Barbara Cole is such a case. Even if all the information available to the review been shared among all the agencies that provided it, Ryan would not have been identified as someone who was presented a high risk of killing anyone and in particular his mother.

**6.3 Conclusion: - Agencies that failed to act on Ryan's disclosure of childhood abuse either did not have suitable policies and procedures in place to manage such disclosure or if they did, their staff are failed to implement them.**

- 6.3.1 The fact that Ryan had the potential to kill his mother or anyone else could not have been reasonably anticipated does not mean that the likelihood of it happening could not have been reduced. There will have been occasions when intervention by agencies, unbeknown to them, has prevented murder. Intervention is most likely to succeed if it is based on the needs of an individual rather than a formulaic approach.
- 6.3.2 Looking at Ryan as a potential victim there are two significant issues in his dealings with agencies – his disclosure that he suffered childhood abuse and the failure to respond to it. His allegations are recorded as being about physical and/or sexual abuse and on occasions he named a perpetrator; his father. He always volunteered the information and on only one occasion was it further explored, and then he did not wish to expand on it. Whether those he did disclose to lacked a basic understanding of how to deal with such disclosures or failed to appreciate how significant they were to Ryan, only they know. Whatever the reason, the allegations were always made when he was angry or talking about his anger and those listening failed to grasp the opportunity to respond.
- 6.3.3 Ryan has serious mental health issues, and for this and other reasons known only to him, he may have fabricated the complaint of abuse he made while in custody and those he made previously. However, those professionals to whom he made the complaints were not in a position to establish whether he was speaking the truth or not and, given the seriousness of them, they should have shared the information with those who had the experience and resources necessary to investigate them more fully.
- 6.3.4 The terms of reference for this review do not include establishing motives for Ryan killing his mother. However, the reader may be drawn to the conclusion

that his disclosures of abuse by his father, coupled with the single mention of his mother not supporting him in this regard, provide a motive. This in turn may lead to the conclusion that the failure of agencies to act on his disclosures was a significant contributory factor to Barbara's death. When Ryan was interviewed by a psychiatrist after his arrest but prior to his trial, the diagnosis was that he suffered from paranoid schizophrenia. The responses he gave as to why he killed his mother were that:

- he was to inherit two valuable properties (in the USA) but his mother was preventing this;
- he wanted to inherit these properties to sell them and donate the proceeds to the Queen;
- these properties came with a 'licence to kill';
- his parents were in the IRA and they intended to sell the properties to buy weapons for the IRA; and
- that his parents had for many years been in the IRA.

6.3.5 The abuse he had previously disclosed is not listed and to conclude that a better response to these disclosures would have prevented or reduced the risk of him killing his mother is not supported by evidence.

**6.4 Conclusion: - Agencies that failed to act on Ryan's disclosure that he was a domestic abuse perpetrator either did not have suitable policies and procedures in place to manage such disclosure or if they did, their staff are failed to implement them.**

6.4.1 Although the nature of the disclosure is different to the previous conclusion, in particular because this one relates to Ryan as a perpetrator rather than a victim, the principle is the same. It would be unreasonable to conclude that responses to the disclosures would have prevented Barbara's death but they should have been acted upon.

## 7. Lessons Learned

- 7.1 When clients/patients make disclosures to agency professionals about matters that could amount to serious criminal offences, there should be policies and procedures in place to ensure that staff know what action they are required to take. That action must be implemented and there must be checks in place to ensure that it has been.
- 7.2 Where agency professionals believe that a person's aggressive behaviour may be the result of mental illness, particularly when that person is regular contact with children or vulnerable people, consideration should be given to conducting a core mental health assessment of that person.
- 7.3 A joined up approach between NHS Trusts that provide mental health services is essential to ensure that if a person who has received diagnosis and/or treatment for mental health issues in one Trust area moves to another Trust area, the latter can easily gain access to the person's medical records from the former.
- 7.4 The handover of cases from one practitioner to another in professional agencies needs to be formally and fully documented to ensure that the handover is seamless. Effective supervision of handovers is a key element in ensuring that this happens.

## 8. Recommendations

8.1 The following recommendations arise from this DHR:

	<b>Recommendation</b>	<b>Agency</b>
1	Staff should be aware of their roles and responsibilities in the implementation of domestic abuse policies and procedures, and of the resources available to assist them.	Kent NHS Community Healthcare Trust
2	Consideration should be given to recording the rape complaint made against Ryan Cole in 2000 in accordance with the Home Office counting rules for crime and incidents and to investigating the circumstances of it. If the decision is to do neither or one of these actions, the rationale should be clearly recorded.	Kent Police
3	When GP surgeries change their IT systems they must ensure that the medical records of current and previous patients are transferred from the old system to the new or that the records on the old system are archived in a way that makes them readily available.	NHS England
4	Agencies must have victim focussed policies and procedures in place to deal with disclosures made by patients/clients that they are victims of historical child abuse, both in terms of their own agency response and how they share the information.  Staff must be aware of the policies and procedures, and where necessary trained in their implementation.	NHS England Sussex NHS Partnership Trust  Kent & Medway NHS Social Care Partnership Trust  Surrey & Sussex Probation Trust
5	Agencies must have victim focussed policies and procedures in place to deal with disclosures made by patients/clients that they are perpetrators of domestic abuse, both in terms of their own agency response and how they share the information.  Staff must be aware of the policies and procedures, and where necessary trained in their implementation.	NHS England  Kent County Council Specialist Childrens Services
6	When it is known or suspected that a patient presenting with mental health issues has received previous treatment from another agency for mental health issues, the patient's medical notes relevant to that treatment should be obtained.	Kent & Medway NHS Social Care Partnership Trust
7	Staff in supervisory positions should be trained in and understand the responsibility they have for checking the work of their staff to ensure that it has been completed in accordance with policies and procedures.	Surrey & Sussex Probation Trust  Kent Probation Trust

8	When information is received that premises in which children are living are being used for drug dealing, this information should be shared with the police.	Kent County Council Specialist Childrens Services
9	Where the responsibility for a case is transferred from one Social Worker to another, the author of the Transfer Summary must ensure that the details contained within it are accurate and complete, particularly those that directly impact on the safety of children and/or staff.	Kent County Council Specialist Childrens Services