BC / 2012

Domestic Homicide Review

Executive Summary

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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.

1. Introduction

This domestic homicide review (DHR) examines the circumstances surrounding the death of Barbara Cole (aged 45+ years) in Town A, Kent. Her son, Ryan Cole (aged 25+ years) pleaded guilty to her manslaughter and was sentenced to be detained indefinitely under the Mental Health Act 1983.

2. The Review Process

2.1 This section outlines the process undertaken by the Kent DHR panel in reviewing the killing of Barbara Cole. The review began with an initial meeting on 31 July 2012 of all agencies that potentially had relevant contact with Barbara prior to her death.

Agencies participating in this review are:

- Police
- National Health Service (NHS)
- National Offender Management Service
- Kent County Council
- Kent Fire & Rescue Service
- Kent Area Housing Services

2.2 Ryan Cole lived in Sussex for a period of about 4 years ending in late 2007; prior to and after this he lived in Kent. The contact he had with agencies in Sussex was such that they were asked to provide Individual Management Reports (IMRs), which were submitted through their counterparts in Kent.

2.3 Agencies were asked to give chronological accounts of their contact with Barbara and Ryan prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with Barbara and Ryan;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's point of view.

2.4 The accounts of involvement with the Barbara and Ryan cover different periods of time prior to the Barbara's death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

2.5 A wide range of voluntary and statutory agencies across Kent were contacted in order to find out which had had involvement with Barbara and/or Ryan. When it became clear that Ryan had spent relevant time in Sussex, agencies there were also contacted. The following from responded to indicate that they had had involvement:

- Kent Police
- Sussex Police
- NHS Kent
- NHS Sussex
- Kent Probation Trust
- Surrey & Sussex Probation Trust
- Kent Specialist Children's Services
- Kent [Housing] Services
- Kent Fire & Rescue Service

2.6 During the course of the review no information has come to light to suggest that any other statutory or voluntary agencies had relevant contact and/or involvement with Barbara or Ryan.

3. Terms of Reference

The terms of reference of this review are:

1. *The Purpose of This DHR*

   To:

   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.*

2. *The Focus of This DHR*

   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.

   If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

   If such 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. Methodology

This review will be based on 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.

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 training/experience of the professionals involved.

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.

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:

Alias	***Year of Birth***	***Mother's Name***
Child E	*2000*	*Rachel Cole*
Child A	*2009*	*Lisa Prout*
Child B	*2011*	*Lisa Prout*

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.

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 the criteria for chronology set out in the paragraph above, 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.

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.

4. *Specific Issues to be Addressed*

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?*

ix. *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, training, management and supervision, working in partnership with other agencies and resources?*

x. *How accessible were the services to Barbara Cole and Ryan Cole?*

xi. *To what degree could the death of Barbara Cole have been accurately predicted and prevented?*

xii. *Were there any allegations or concerns about domestic abuse towards Ryan Cole's mother and/or father? If so, what action was taken?*

xiii. *Were there any allegations of sexual abuse committed against Ryan Cole by his father and/or any other person? If so, what action was taken?*

4. Key issues arising from the review

4.1 There is no evidence or information to suggest that Barbara had been a victim of domestic abuse at the hands of anyone prior to the attack that led to her death. She had no contact or involvement with any agencies that would have given them cause to think that she was likely to be a victim. For these reasons, this review focuses almost entirely on Ryan and whether any lessons can be learned from the contact and involvement he had with agencies.

4.2 Ryan had learning difficulties; he suffered from dyslexia and was illiterate. He presented to General Practitioners (GPs) on a number of times up to 2010 and was referred to secondary mental health services on each occasion. In 2005 he was diagnosed as suffering from borderline anti-social personality disorder traits along with associated psychotic symptoms, and an underlying depressive disorder could not be ruled out. He was also known to be a long-term heavy user of cannabis. Although Ryan was referred to secondary mental health services, he became very difficult to engage with and was last seen by a psychiatrist in November 2007; more than 4 years before he killed his mother. He was initially seen by Sussex NHS and his records were never transferred to Kent NHS, although a request was sent.

4.3 Ryan admitted to a number of agencies that he was a perpetrator of domestic abuse and was known by other to be one. This abuse related to at least two female partners and he was a victim of domestic abuse in at least one relationship. The level and frequency of violence that he used as a perpetrator was relatively low; below that which would have warranted him being considered as a MAPPA subject. He had been cautioned for a number of offences prior to killing his mother but in the seven years prior to her death he had only one conviction; for harassing an ex-partner, for which he received a Community Order.

4.4 In addition to his mental health issues, Ryan disclosed to professionals on a number of occasions that he been the victim of historic child physical and/or sexual abuse and he cited his father as the offender. Although these disclosures were recorded, they were never acted upon and in particular the police were not aware of them until after he was arrested for killing his mother.

5. Conclusions and recommendations from the review

5.1 The conclusions from this review are:

1. There is no evidence or information that Barbara had been a victim of domestic abuse prior to her death.
2. No agency could reasonably have foreseen Ryan's potential to kill his mother or anyone else.
3. Agencies which 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 failed to implement them.
4. 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.

5.2 The recommendations from this review are:

	Recommendation	Agency
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 historic 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