Trafford Community Safety PARTNERSHIP

A Domestic Homicide Review of the death of Dyanne

March 2021

EXECUTIVE SUMMARY

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1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Trafford Partnership Domestic Homicide Review Panel in reviewing the death of Dyanne, who is resident in their area. This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004. Dyanne was killed by her husband in March 2021. In July 2022, her husband was acquitted of her murder but convicted of manslaughter when the jury at Manchester Crown Court accepted the legal defence of a 'suicide pact.'

1.2 Usually, pseudonyms are used in a Domestic Homicide Review, to protect the identity of the victim and perpetrator. However, in this case, Dyanne's family expressed a wish to use her real name. Likewise, the perpetrator, Graham, also expressed a wish to be referred to by his own name. Since the acquittal for murder, Graham has conducted a number of interviews with the Press and on television, related to the issues of suicide pacts and 'mercy killings.' In view of this, plus the fact that the couple had no children, the wishes of the family have been respected.

Subjects of the Review:

- The victim; Dyanne, a female aged 71 years at the time of her death.
- The perpetrator; Graham, a male aged 72 years at the time of the incident.

1.3 The review began on 19th November 2021 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 14th January 2022. This was convened remotely due to the restrictions in place with the COVID-19 pandemic. The panel met again on 11th May and 7th September 2022. The review was concluded in October 2022.

1.4 The DHR was affected by the COVID-19 pandemic. Although many restrictions had eased, panels were held remotely. They still gave the opportunity for valuable and constructive dialogue and challenge. Additional time was allocated to professionals who had extra responsibilities and pressures stemming from a backlog of work during the pandemic.

1.5 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself."

1.6 The statutory guidance states the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

- To establish whether the events leading up to the homicide could have been predicted or prevented.

2. Contributors to the review

2.1 Initial scoping suggested that most agencies in Trafford had very limited involvement with both subjects of the review.

- Neither perpetrator nor victim had any previous involvement with the police or probation services.
- They had no children.
- They were not known to have used controlled substances.
- They were not known to mental health services.
- They owned their own home and had no involvement with any housing support services or Registered Social Landlords.
- The only organisations that had contact with the couple were various health agencies.

2.2 Several agencies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) were requested and provided. The review chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview report author. Interviews with staff would also form part of the learning.

2.3 The following organisations were required to produce an Individual Management Review:

- Trafford Clinical Commissioning Group (on behalf of the GP Practice)
- Manchester University NHS Foundation Trust
- Northwest Ambulance Service
- The ‘Christie’ (specialist cancer care hospital)

The IMR authors were completely independent and had no role in any of the decisions made or actions undertaken by their respective agencies prior to Dyanne’s death.

3. The Review Panel members

3.1 The Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

3.2 The Domestic Homicide Review panel is comprised of the following people:

- Mike Cane - Independent Chair and Author
- Georgina Cartridge, Deputy Designated Practitioner, Adults and Children's Safeguarding, Trafford Clinical Commissioning Group
- Andy Craggs, Named Nurse, Adult Safeguarding Team, Wythenshawe Trafford Withington and Altrincham Hospital, Manchester University NHS Foundation Trust
- Detective Inspector Iain Butler, Investigation and Safeguarding Review Unit, Greater Manchester Police
- Rhys Dower, Domestic Abuse Manager, Trafford Council
- Jane Whittaker, Safeguarding Practitioner, Northwest Ambulance Service NHS Trust
- Kirsty McAllister, Trafford Domestic Abuse Service
- Linda Allen, Safeguarding Lead Nurse, 'The Christie' NHS Foundation Trust
- Jilla Burgess-Allen, Consultant, Public Health, Trafford Council
- Lee Turnbull Service Development Manager, AGE UK, Trafford

The panel included specialists in providing domestic abuse services.

Following dialogue at the first DHR panel, specialists from AGE UK and suicide prevention services were also invited to attend from the second panel meeting.

None of the panel members had any direct dealings with the subjects of the review nor had management responsibilities to any front line worker involved with any of the subjects.

4. Author of the overview report

4.1 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the Safer Trafford Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding, investigation of child abuse, rape & other serious sexual offences and abuse of vulnerable adults. He has extensive experience as an author and panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

Mike has completed DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as AAFDA training on 'involving children in DHRs' in 2021. He has also designed and delivered domestic abuse training (identification, risk assessment and risk management) to staff across the public and voluntary sector.

5. Terms of Reference for the review

5.1 The terms of reference were agreed at the convening of the first DHR panel:

- Were practitioners sensitive to the needs of the victim? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns?

- Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

- Did the agency comply with any agreed multi-agency information sharing protocols?

- 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?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- Was there a change in the carer relationship between husband and wife? In view of the victim's physical debilitation, was this ever assessed?

- Were there any changes in circumstances that created additional pressures (e.g. employment, routines, hobbies or finances)?

- What information was known about the perpetrator/partner? How accessible were services?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Did any restructuring during the period under review have any impact on the quality of service delivered?

- Did the Covid-19 pandemic impact on the delivery of services?

6. Summary chronology

6.1 This chronology covers relevant contacts between the victim and professionals during the agreed date parameters for this Domestic Homicide Review. Agencies examined their records for five years before Dyanne's death. These agencies also secured records of contacts with the perpetrator. Several of Dyanne's contacts with medical professionals are recorded in the main overview report for this DHR, but not all are listed in this summary chronology. The only contacts with the perpetrator were a few unrelated medical appointments. These had no direct relevance to this review and so are not included.

6.2 On 4th August 2020, Dyanne had a telephone consultation with her GP. There was a national lockdown in place during the Covid-19 pandemic and all routine face to face appointments had been cancelled. Dyanne had an ongoing cough for the last four months. Medication was prescribed and a follow-up appointment was arranged.

6.3 On 17th August Dyanne had another telephone consultation with her GP. Her previous symptoms were worsening. She required an x-ray and a review.

6.4 On 27th August Dyanne again contacted the GP Practice. Her medication was not working. Her cough and respiratory symptoms remained. She was prescribed inhalers.

6.5 On 14th September, the GP informed Dyanne of her chest x-ray results and that she had suspected lung cancer. A fast track referral was made.

6.6 Between 23rd September and 13th October, Dyanne had five face to face appointments with the Wythenshawe, Trafford, Withington and Altrincham (WTWA) Outpatient Department of Respiratory Medicine and Urology. On four of these visits she was accompanied by her husband. All the appointments related to Dyanne's cancer diagnosis and treatment.

6.7 On 24th September 2020 North West Ambulance Service received a '999' call from a healthcare professional at Dyanne's home. Dyanne had a headache and was vomiting. She had a CT scan the day before for possible lung cancer. Dyanne did not want to attend hospital. Pain relief was administered by the ambulance crew and Dyanne was left in the care of her husband.

6.8 On 21st October, Dyanne and Graham attended their first appointment with the oncologist at the 'Christie' specialist cancer care hospital. They were informed that Dyanne's cancer was a terminal illness. Staff notes state they were both shocked by this news.

6.9 On 1st December, Dyanne had another appointment at the Christie Hospital. She had developed quite significant fatigue following her first chemotherapy treatment. Dyanne reported she had a lack of motivation to do the things she would normally enjoy doing.

6.10 Between January and March 2021 the District Nursing Team carried out home visits to care for Dyanne on ten occasions.

6.11 On 13th January, a healthcare professional from the 'Christie' called '999' for an ambulance. Dyanne had chest pain and reported she was undergoing chemotherapy. The ambulance crew documented they advised she went to hospital but Dyanne declined to go. She stated she was worried about Covid. The paramedic also contacted the Christie. They had also advised Dyanne should go to hospital but she would not be persuaded.

6.12 On 18th January a referral from the GP (routed via the Christie Hospital) was received by the Specialist Palliative Care Team (SPCT) for ongoing support. The SPCT nurse visited Dyanne on three occasions.

6.13 The last contact with Dyanne by any professional was made on 22nd March 2021. This was a home visit by the District Nursing Team. Dyanne was found dead by police the following evening.

7. Key issues arising from the review

7.1 The couple who are subject to this review were married for 40 years. They had no children and lived a quiet life.

7.2 Both the victim and the perpetrator had little or no involvement with statutory or voluntary services.

7.3 The victim had suffered from episodes of poor health over many years but had made good recoveries. She had been treated for cancer on several previous occasions from the 1990s, in 2002 and 2004. Although she was ‘disease free’ after treatment for bladder cancer in 2004, the diagnosis in 2020 is noted as a ‘relapse’ with CT scans showing the lung and chest areas infected.

7.4 The victim was diagnosed with a terminal illness (lung cancer).

7.5 There were no incidents of domestic abuse reported to the police or any other agency throughout their long, married life.

7.6 No concerns or suspicions of domestic abuse, or coercive control were ever noted by any professional that supported Dyanne and Graham.

8. Conclusions and Lessons Learned.

8.1 Both Dyanne and Graham had very little contact with services. Indeed, other than during Dyanne's (terminal) illness, contact with services was almost non-existent.

8.2 Due to Graham being arrested and subsequently charged with his wife's murder, this case was correctly assessed to meet the criteria to conduct a Domestic Homicide Review. However, it should be noted that there was never any indication of any domestic violence or abuse taking place over their very long marriage. There was never an incident reported to the police. Family and neighbours never witnessed any behaviour that indicated any degree of control or coercion. The couple always appeared relaxed in each other's company. No professional, either before or during Dyanne's terminal illness ever noted any 'atmosphere' between Dyanne and Graham.

8.3 The onset of the Covid-19 pandemic exacerbated an already traumatic time for Dyanne and Graham. They were a very active couple who enjoyed a number of activities and hobbies together and in company with friends and family. Dyanne's illness meant that these activities were quickly curtailed due to her physical frailty. But the Covid-19 lockdown restrictions meant that in addition to absorbing the reality of Dyanne's terminal illness they were also isolated from family and friends.[1]

8.4 Another aspect stemming from the Covid-19 restrictions relates to the anxiety of Dyanne contracting Covid whilst attending hospital. It is well documented that the chances of contracting Covid-19 increase significantly within a hospital environment. For Dyanne and Graham this meant significant concerns that if Dyanne did contract Covid it was much less likely she would be able to return home. If that was the case, then her husband may not have been able to visit her and she would have been alone without family support. Covid-19 increased Dyanne's overall anxiety and introduced new situations which caused her stress. Research suggests these additional worries have resulted in individuals contemplating suicide or meant couples considered a suicide pact. [2]

8.5 Dyanne was treated with dignity and respect during her illness. She received excellent medical care from dedicated professionals. When

[1] Vulnerability, Knowledge and Practice Programme (Home Office, National Police Chief's Council, College of Policing 2020-2021)

[2] Covid -19 Suicidal behaviour amongst couples and suicide pacts: Case study evidence from press reports (Mark D Griffiths and Mohammed A. Mamun May 2020)

Graham became understandably concerned or frustrated at his wife's rapid deterioration in health, he was able to express these concerns directly with medical professionals. There is evidence of information exchange between various medical services.

8.6 There was a lot of contact with health practitioners in the last few months of Dyanne's life. This included a significant amount of contact within the family home. Due to existing protocols with both the District Nursing Team and the Ambulance Service, there were many occasions when Dyanne received treatment on her own. Her husband would leave the room while assessment or treatment was undertaken. This afforded many opportunities for Dyanne to raise a concern if she had any. Nothing was ever disclosed to professionals during this very difficult time.

8.7 Graham was charged with murder as he admitted to killing his wife and intending to kill her. His defence was they had agreed a 'suicide pact'. This defence was accepted by the Crown Court. The Jury took only 90 minutes to acquit him of murder. He was convicted of manslaughter but did not receive a custodial sentence. He was given a sentence of two years imprisonment, suspended for two years.

8.8 The Crown Prosecution Service changed its guidelines for lawyers earlier this year. The previous default position was to charge and let the courts decide. This has shifted to look for any evidence of a suicide pact and not automatically take the case to court. This needs to be measured as there is always a possibility that coercion may be involved.

8.9 Dyanne and Graham had been married for 40 years. Dyanne's lung cancer diagnosis was only weeks after they celebrated their Ruby Wedding anniversary. In the Judge's summing up at Graham's trial he stated "This was an act of love. The law allows for a suicide pact as a mitigating factor. If you are part of a suicide pact and fail to take your own life you will be convicted of manslaughter".

8.10 This tragic incident involved a husband perpetrating significant violence to the woman he loved. It was part of a suicide pact. This was the decision of the Crown Court. He made a determined effort to take his own life at the same time but did not manage to do so.

9. RECOMMENDATIONS

9.1 During the Domestic Homicide Review, the panel kept an open mind on the presenting circumstances. Opportunities for alternative actions or decisions by staff engaged in the care of Dyanne were reviewed. However, there was never any indication of domestic abuse in any form. In particular, it was good practice that several staff from different organisations did speak to Dyanne alone and this gave an opportunity for her to disclose anything of concern if she was worried.

Recommendation 1

All professionals within the Safer Trafford Partnership to be briefed on the contents of this case. Although there were no shortcomings in practice, it would be helpful that practitioners involved in supporting patients and their families during a terminal illness are aware of the potential for a 'suicide pact' and how to escalate or seek advice in such circumstances.

Recommendation 2

Any practitioner involved in the assessment or treatment of a terminally ill patient or service user should conduct a risk assessment to include considerations around the potential for a suicide pact. This should be a continuous process, as health deteriorates and pressures on family members increase.

Recommendation 3

The Safer Trafford Partnership reviews its multi-agency Information Sharing Protocol to give guidance and advice to professionals who may be dealing with domestic abuse incidents or have concerns about potential domestic abuse and coercive control.