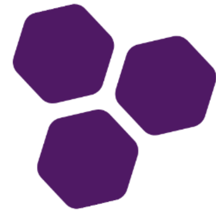

Domestic Homicide Review

Dyanne

March 2021

Report Author: Mike Cane

Dated: 10th October 2022

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Section 1: Introduction

1.1 This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004. It follows the death of a female in Trafford in March 2021. The perpetrator was her husband who was charged with the murder of his wife. He was subsequently acquitted of murder but convicted of manslaughter at Manchester Crown Court in July 2022.

1.2 The review examines agency responses and support given to the victim prior to her death in March 2021. It will also consider the actions and decision-making of professionals regarding their contact with the perpetrator.

1.3 In addition to agency involvement the review will examine the past, to identify any relevant background or potential abuse before the death, whether support was accessed and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify lessons that can be learned from this tragic death.

1.4 The circumstances of the death were initially provided by Greater Manchester Police to the Chair of the Safer Trafford Partnership (by secure email to the Community Safety Department at Trafford Council) on 9th August 2021. An earlier email was sent on 25th March 2021 but never arrived due to a technical glitch. (It was only when Greater Manchester Police chased up the email, at the end of Covid restrictions in August, that it became apparent the email had not arrived.) A Domestic Homicide Screening Meeting took place on 10th September 2021. The multi-agency delegates from that meeting recommended the death met the criteria for a Domestic Homicide Review. This recommendation was subsequently ratified by the Chair of Safer Trafford Partnership.

1.5 It is standard practice to protect the identities of individuals involved in a DHR by using pseudonyms within the overview report. However, the victim's family have specifically requested that her real name is used throughout the document. Her husband, the perpetrator, will also be known by his real name. The Domestic Homicide Review panel carefully considered whether to use their real names and considered the following factors:

- The stipulations set out within the national statutory guidance for the conduct of DHRs
- The impact on family, friends and professionals who were involved with the victim in the lead up to her death
- The potential identification of the perpetrator
- The potential for the victim to be identified, regardless of whether the report was anonymised

— There have been previous DHRs published using a victim's real name for good reason (i.e. a precedent had been set).

When considering these factors, the panel noted the statutory guidance states:

" The benefits of involving family, friends and other support networks include…. Enabling families to choose, if they wish, to use a pseudonym for the victim to be used in the report. Choosing a name rather than using initials, letters or numbers, humanises the review and allows the reader to follow the narrative more easily. It would be helpful if reports outline where families have declined the use of a pseudonym."

The panel discussions also included that the death took place in a quiet residential area where the victim and perpetrator were known within that community. The death and subsequent trial were reported in the local and national media. Following his conviction, the perpetrator has taken part in television interviews and articles in the printed Press, relating to suicide pacts, 'mercy killings' and assisted suicide.

1.6 The review will consider all agency contact / involvement with the victim and perpetrator from 24th March 2016 through to the date of the victim's death on 24th March 2021 (a five year timeframe). However, the panel agreed that if further relevant information were discovered from before those dates then this would also be included in their chronologies and considerations.

1.7 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Section 2: Timescales

2.1 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.

2.2 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 crisis.

2.3 The DHR process began while the criminal investigation was ongoing. The initial trial date (May 2022) was adjourned and put back to July 2022 while a specially trained High Court Judge was appointed. Although much of the review of agency records could still take place, this did prevent progress on some aspects of the family liaison and speaking to professionals about their recollection of events.

Section 3: Confidentiality

3.1 The content and findings of this review will be ‘confidential’, with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

3.2 The victim, Dyanne, was 71 years old at the time of her death. Her husband, Graham, was 72 years old at that time. They were both British citizens residing permanently in the UK. Their ethnicity is white/British.

Section 4: Terms of Reference

4.1 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?

Section 5: Methodology

5.1 The decision to undertake a Domestic Homicide Review was collectively agreed by members of the Safer Trafford Partnership on 10th September 2021. This followed detailed debate and consultation with all relevant partner agencies at the DHR Screening meeting.

5.2 The aim of the DHR panel was to deliver the review as soon as practicable. The criminal trial process began after the start of the Domestic Homicide Review. Indeed, the perpetrator was charged with murder on the same date as the convening of the first DHR Panel. There were delays in the criminal trial but the DHR Panel Chair is confident the review maintained focus and the final report was completed in good time.

5.3 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 she was related or with whom she was or had been in an intimate personal relationship, or

b) A member of the same household as herself."

5.4 For this review, the term domestic abuse is in accordance with the statutory definition of domestic abuse within the Domestic Abuse Act 2021:
'Definition of "domestic abuse"

(1) This section defines "domestic abuse" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected", see section 2.

2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if—

(a) the person is a parent of the child, or

(b) the person has parental responsibility for the child.

(3) In this section—

- *“child” means a person under the age of 18 years;*
- *“civil partnership agreement” has the meaning given by section 73 of the Civil Partnership Act 2004;*
- *“parental responsibility” has the same meaning as in the Children Act 1989 (see section 3 of that Act);*
- *“relative” has the meaning given by section 63(1) of the Family Law Act 1996.*

5.5 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

5.6 The Safer Trafford Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

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.

Section 6: Involvement of family, friends, neighbours and wider community

6.1 Dyanne has one sibling; her older brother. She had no children. Early contact was made with her brother via a telephone call. He was being supported by a homicide case worker at Victim Support Services. Due to the pending criminal trial at the Crown Court, the Independent Chair for the Domestic Homicide Review explained that any detailed discussions about the case were not possible until after the conclusion of the trial. The brother accepted this but agreed to meet with the Independent Chair once criminal matters were concluded.

6.2 Following Graham's acquittal for the murder of his wife, Dyanne, he took part in a number of interviews both on television and in the Press. The Independent Chair made contact with Graham and explained the DHR process. Graham told the Independent Chair:

"*We never thought we were breaking any laws. We didn't need permission. When Dyanne was poorly, I gave her my word she wouldn't go into hospital. She was adamant she didn't want to die in hospital. We lived together all those years and we wanted to die together. None of this would have happened if I had managed to kill myself."*

6.3 Graham did acknowledge it was difficult for medical professionals during Covid-19 restrictions but that he appreciated the efforts of most involved in Dyanne's care. He did want to note that he and Dyanne were not satisfied with the service they received from their GP Practice. He stated "We got no help or support from our GP. They never phoned us to explain what was going on or to provide some reassurance. It was always me having to phone them".

6.4 Graham confirmed that the Covid-19 pandemic made an already very difficult situation much worse. He told the Independent Chair that just after their 40th Wedding Anniversary, he and Dyanne had gone on a 20 mile bike ride then on several lengthy hikes in the countryside. It was a shock to get Dyanne's terminal diagnosis. Suddenly, she was very ill, and with Covid restrictions, they lost all face to face contact with family and friends.

6.5 Following several telephone calls and liaison with Victim Support Services, the Independent Chair travelled to meet with Dyanne's brother in August 2022. They discussed the tragedy, his sister's terminal illness and the nature of the relationship between Dyanne and Graham. Her brother stated they 'did everything together'. Dyanne's brother is absolutely sure there was never any domestic abuse or coercion or control between Graham and Dyanne. They were happily married for over 40 years and he never once had any concerns that there was any form of abuse in the relationship. He was shocked when Dyanne was killed. However, he and Graham have

remained close and he supported Graham during the criminal trial. He knows that Graham is now engaged in work examining 'assisted dying' and so-called 'mercy killings'. He misses his sister very much.

Section 7: Contributors to the Review

7.1 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.

7.2 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.

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

- Greater Manchester NHS Integrated Care System (Trafford) -on behalf of the GP Practice

- Manchester University NHS Foundation Trust

- North West Ambulance Service

- The Christie NHS Foundation Trust (a specialist cancer centre)

Section 8: The Review Panel Members

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

8.2 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, GM NHS ICS (Trafford)
- Andy Craggs, Named Nurse, Adult Safeguarding Team, Wythenshawe Trafford Withington and Altrincham Hospital, Manchester University NHS Foundation Trust
- Iain Butler, Review Officer, Investigation and Safeguarding Review Unit, Greater Manchester Police
- Rhys Dower, Domestic Abuse Manager, Trafford Council
- Jane Whittaker, Safeguarding Practitioner, North West 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 DHR panel members had any direct management or oversight of this case.

Section 9: Author of the overview report

9.1 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 and 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.

Section 10: Parallel Reviews

10.1 The inquest into Dyanne's death was commenced and then adjourned pending the criminal trial process. The inquest was still pending at the conclusion of the DHR process.

10.2 There were no children involved in the review process and so no requirements for any consideration of a Child Safeguarding Practice Review.

10.3 None of the subjects of the Domestic Homicide Review had been assessed nor were in receipt of services, under the Care Act 2014.

There was no requirement for a Safeguarding Adult Review. However, the completed DHR, including conclusions and recommendations, will be shared with the Trafford Strategic Safeguarding Partnership.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim was married at the time of her death. Their marital status does not appear to have affected any of the services provided.

11.3 No issues were identified during this review applicable to sex, gender reassignment, race or religion.

11.4 Sex was not an adverse issue. Data from the Office for National Statistics shows of the 5224 victims of suicide in England & Wales in 2020, 75% were male. There is no sex or gender data available for 'suicide pacts'.

11.5 Neither the victim nor the perpetrator were recorded with any disability.

Section 12: Dissemination

12.1 The following organisations will receive a copy of the report after any amendment following the Home Office's quality assurance process:

- The perpetrator's Offender Manager, the Probation Service
- All organisations within the Safer Trafford Partnership
- The Trafford Strategic Safeguarding Partnership
- The DHR panel for Trafford
- The Home Office DHR team
- The Mayor's Office for Greater Manchester
- The Domestic Abuse Commissioner's Office

Section 13: Background Information (the facts)

Case specific background

13.1 The victim, Dyanne, was born in 1949 in the UK. She was married for over 40 years to Graham. She was 71 years old at the time of her death. She had worked as a clerical officer/administrator prior to her retirement. Dyanne had serious health issues. In 1999 she was diagnosed with bladder cancer for which she received treatment. In 2002 she had breast cancer and then in 2004 she was again diagnosed with bladder cancer.

13.2 The perpetrator, Graham, was born in 1948 in the UK. He was 72 years old on the day of the incident. He has some medical issues but could be considered in good health for a man of his age.

13.3 Dyanne and Graham lived a quiet life. They did not have children and had never been in any sort of trouble with the police. Neither had ever been arrested for any offence and neither had any dependency on drugs or alcohol.

13.4 Dyanne was diagnosed with cancer - Metastatic Transitional Cell Carcinoma (TCC); Metastases to lungs and thoracic lymph nodes, in October 2020. The disease was a terminal illness. The chronology section of this review will examine details of the subsequent medical appointments and contact with professionals.

13.5 On 24th March 2021 police received a '999' call from Graham. He stated he had cut his wife's throat the previous evening. He also stated he had cut his own throat. The first police officer arriving at the scene found Dyanne dead in the back garden. Graham was also present and had a cut to his throat, two cuts to his right wrist and three cuts to his left wrist. Graham was arrested at the home, then escorted by police when he was conveyed by ambulance to Manchester Royal Infirmary for his wounds to be assessed and treated. He left hospital the following day and was taken to the police station for further enquiries and interview.

13.6 On 14th January 2022, Graham was charged with his wife's murder. A trial date was set for 23rd May. Matters were further adjourned and the trial began on 18th July 2022 at Manchester Crown Court. Graham was acquitted of murder but convicted of the manslaughter of his wife. His defence, which was accepted by the Jury, was that it was a suicide pact. Dyanne had consented to the act and that Graham had every intention of killing himself.

Section 14: Chronology

14.1 This chronology covers any relevant contacts between the victim and professionals during the agreed date parameters for this Domestic Homicide Review. Agencies agreed to examine their records for five years before Dyanne's death. These agencies also secured records of contacts with the perpetrator. However, 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.

14.2 As has already been noted, Dyanne had suffered with cancer previously. She had treatment for bladder cancer in 1999 and for breast cancer in 2002. She was again diagnosed with bladder cancer in 2004.

14.3 On 8th March 2019 Dyanne had an appointment with her GP. She had suffered hypertension when recently attending the Withington Hospital for a cystoscopy. The GP found Dyanne's blood pressure was outside the normal range. However, she declined to commence any hypertensive medication. The plan was to review in one week.

14.4 At the follow-up appointment on 15th March, Dyanne again stated her reluctance to start any medication to manage her hypertension (she remained mildly hypertensive at the review on 5th April 2019).

14.5 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.

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

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

14.8 On 10th September, the GP Practice received the chest x-ray results. Staff attempted to contact Dyanne by telephone but there was no reply.

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

14.10 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.

14.11 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.

14.12 On 13th October, Dyanne saw her GP for her first face to face appointment since her cancer diagnosis. This appointment was for her influenza immunisation.

14.13 On 21st October, Dyanne and Graham attended their first appointment with the oncologist at The Christie NHS Foundation Trust (specialist cancer centre). They were informed that Dyanne's cancer was a terminal illness. Staff notes state they were both shocked by this news.

14.14 On 17th November 2020, Graham called The Christie to inform staff his wife was struggling with her appetite. She was still mobile and was able to move around the house. He was signposted to the GP for review of her diet.

14.15 On 1st December, Dyanne had another appointment at The Christie. 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.

14.16 On 16th December 2020, Dyanne's husband contacted the GP due to side effects of the chemotherapy treatment. Medication was prescribed. There was no consultation with the patient. However, the GP did contact the District Nursing Team for support with a catheter, pressure area and wound care needs.

14.17 Dyanne had an appointment with the consultant radiologist at The Christie on 18th December. The notes state:

'*There is now complete occlusion of the left upper lobe bronchus with progressive collapse of the left upper lobe. The cause is malignant disease at the left pulmonary hilum which involves the central portion of the left upper lobe.'*

14.18 There was a further review appointment with Dyanne at The Christie on 9th January 2021.

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

14.20 On 13th January 2021, Graham telephoned the GP requesting a MacMillan referral for symptom support. The referral was completed.

14.21 Also 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.

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

14.23 On 22nd January, Dyanne visited her GP for her Covid-19 immunisation.

14.24 On 26th January, the District Nurse carried out a home visit. Dyanne was breathless and in pain. Oramorph was prescribed.

14.25 On 2nd February 2021, Dyanne attended The Christie. The notes state:

'*Attended today for review to assess if well enough for the chemotherapy that was deferred last week. Is still struggling with her breathing and feels this has got worse. Left Supraclavicular Fossa mass consistent with known cancer. Not tender.*

Reduced air entry on base of left lung however overall air entry is good. Right lung normal. Has still not tried the Oramorph. We have encouraged her to try this. Worsening of breathlessness could be due to progression of disease and indicating chemotherapy is not working. Discussed with Dyanne that we could wait to confirm this with scan on 4th February however she is keen to continue. To be reviewed next week in clinic to discuss scan results. '

At the scan two days later it was confirmed: *'Progression of disease compared to the previous CT from 23/09/20 with increasing left upper lobe collapse and enlarging left supraclavicular fossa lymph node.'*

14.26 On 25th February, the GP had a discussion with Graham. He reported his wife's chemotherapy side effects persisted. Further medication was prescribed. A similar telephone call asking for help was made by Graham on 5th March.

14.27 On 8th March, Graham rang the hotline at The Christie. He stated Dyanne was 'going downhill'. He said it was not medically urgent, more to discuss what was happening and their options. He reported that his wife had gurgling sounds which made it difficult for her to eat and she was not therefore getting proper nourishment and was having difficulty swallowing. He said she had been ill after her last two cycles of chemotherapy. The member of staff agreed to raise his concerns with the treatment team.

14.28 On 9th March, Graham rang the GP. Dyanne was unable to swallow food and was losing weight. The GP agreed to a face to face consultation.

14.29 On 10th March, the GP made a referral to The Christie for further support to Dyanne. The hospital returned the call to Graham to offer advice and

Dyanne was seen at a clinic the following day. The notes from the oncologist state:

'Will expedite the re-staging CT scan. I will make arrangements to review Dyanne back in clinic to discuss this. I have warned both Dyanne and husband that it is likely to confirm progressive disease. Going forward there may be an option for possible immunotherapy but I have cautioned Dyanne that she may not be fit enough for this option.

1) Please cancel all chemotherapy appointments.

2) Message to radiology to expedite her CT scan.

3) Patient to contact community Macmillan team with summary of today's discussion.

4) Send a copy of annotation to GP with this additional letter.'

14.30 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 on 24th March.

Section 15: Overview

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

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

15.3 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.

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

15.5 The context to this review is the Covid-19 lockdown. This meant isolation from family and friends and some services changing their delivery model (i.e. telephone consultations as opposed to face to face appointments).

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

Section 16: Analysis

16.1 In contrast to the overwhelming majority of Domestic Homicide Reviews, this case had very little contact from statutory and voluntary services. Initial scoping for this review demonstrated that there had never been a single call to the police relating to allegations or concerns about domestic abuse.

16.2 Neither Dyanne or Graham had ever been involved with the police for crime, anti-social behaviour or any other matter. Hence there was also no involvement with the Probation Service. Nor was there any drug and alcohol support service involvement.

16.3 The couple had no children and so there was no involvement from Children's Social Care.

16.4 Following the incident which resulted in Dyanne's death, police carried out enquiries with neighbours. There were never any reports of arguments or shouting from the couple's home.

16.5 There is no doubt that Graham killed his wife and made a serious attempt to end his own life during the same tragic incident.

16.6 With such little agency involvement, it is difficult to analyse the involvement of professionals as there were no signals or suggestions that may have alerted practitioners. The prism to view any such opportunities is narrow but by addressing each of the terms of reference, the review seeks to look objectively at the circumstances.

16.7 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?

16.7.1 All practitioners that had contact with Dyanne in the months leading up to her death were health professionals. Their focus, quite rightly, was on effective management of her terminal illness. There were no 'flags' on any systems within the GP Practice, the Manchester University Hospitals NHS Trust, The Christie or the North West Ambulance Service NHS Trust of any previous incidents of domestic abuse. This is because there were no previous reported incidents of domestic abuse to any agency.

16.7.2 All frontline North West Ambulance Service (NWAS) crews receive training on identifying potential abuse. No crew had any concerns.

16.7.3 Manchester NHS Foundation Trust registered staff must complete mandatory Adult Safeguarding Level 3 training. This includes a large element on domestic abuse, warning signs to look out for and how to complete both risk assessments and referrals. In addition, staff can access themes such as coercive control via online resources. During ten home visits by the District Nursing Team and during appointments at the hospital, there was no indication of any form of coercion or domestic violence.

16.7.4 Age UK (Trafford) were part of the DHR panel though were not involved in supporting Dyanne or Graham. Prior to Dyanne's death, the agency recognised the need to improve their organisational response to older people who may be experiencing domestic abuse. They have an action plan in place to give enhanced knowledge. The plan includes developing the role of domestic abuse champions, improved coordination with other professionals (including information exchange), how to make appropriate referrals and understanding the dynamics of an abusive relationship.

16.7.5 The GP Practice staff access specific training from Trafford Domestic Abuse Service. There are also domestic abuse elements within their Level 3 safeguarding training for adults and children.

16.8 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?

16.8.1 NWAS has a safeguarding policy which covers both adults and children. The policy includes extensive references to domestic abuse and coercive control. Their staff do not conduct individual domestic abuse risk assessments, though they are trained in referral pathways (e.g. to the police or specialist support services) if they suspect any form of domestic abuse.

16.8.2 Manchester NHS Foundation Trust (MFT) has a specific Domestic Violence and Abuse Policy. The policy reinforces to all staff that they must be aware of their roles in relation to domestic abuse so that there is a safe and consistent approach to dealing with domestic abuse across the entire Trust. There was never any suggestion or suspicion of domestic abuse taking place and so risk assessments were not carried out. Staff do receive training in how to conduct a domestic abuse risk assessment to national standards if these were required.

16.8.3 The GP Practice has a safeguarding policy in place which includes sections giving advice to staff on how to deal with disclosures or concerns about domestic abuse.

16.8.4 Age UK (Trafford) also have a comprehensive safeguarding policy in place. The policy recognises how domestic abuse issues can be part of other wider safeguarding concerns. This policy includes advice to staff who may encounter victims or perpetrators of domestic abuse.

16.8.5 The Christie also has a safeguarding policy in place which includes advice and guidance to their staff on how to raise concerns relating to domestic abuse.

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

16.9.1 Information was shared proportionately between medical professionals engaged in the care and treatment of Dyanne. Manchester Foundation Trust and The Christie confirm their safeguarding team is the point of contact for information sharing queries in domestic abuse cases.

16.9.2 Primary Care use safeguarding referrals which are easily accessible in such cases, though these were not required in this case.

16.9.3 NWAS regularly utilise safeguarding referrals (including handovers at hospital, they exchange information from attendances around 6000 times per month).

16.9.4 Age UK (Trafford) recently conducted an internal audit relating to workforce competency and confidence in identifying domestic abuse and making ongoing safeguarding referrals. The training collaboration with TDAS is to develop a specific older person’s domestic abuse learning module which will include information sharing.

16.9.5 No practitioner ever witnessed or suspected any domestic abuse or coercive control. Therefore, no such referral pathways were ever considered. The Safer Trafford Partnership has an Information Sharing Protocol in place, though this document is in need of review.

16.10 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?

16.10.1 The GP Practice maintained contact with Dyanne and Graham. Although appointments were adapted following the restrictions in place with the Covid-19 lockdowns (many contacts were on the telephone rather than in person), there was still occasional face to face contact with Dyanne's GP.

16.10.2 The NWAS crews attended the home of the victim twice; on 24th September 2020 and on 13th January 2021. Staff documented a detailed clinical examination of Dyanne. She was fully consulted on her care needs. It was also recorded that Dyanne had capacity to make decisions about her care. The crews (who are trained in the identification of domestic abuse) did not see anything that gave any indication whatsoever that Dyanne was suffering domestic abuse or coercive control. Crews are also aware of the need to create 'space' so they can engage fully with the patient and make their assessments. Nothing untoward in the home was recorded

16.10.3 Dyanne was seen on 17 occasions by MFT staff. This included ten home visits by the District Nursing Team (DNT). The DNT visits took place between 16th December 2020 and 22nd March 2021. District Nursing Team staff were interviewed as part of this Domestic Homicide Review. No nurse ever noticed any 'atmosphere' between Dyanne and Graham. There was never any discussion about suicide or assisted suicide. Graham was present on each DNT visit (as would be expected as it is their family home). However, Graham would leave the room when treatment for Dyanne's pressure ulcer was taking place. The nurses believed Dyanne always appeared relaxed about her husband's presence.

16.10.4 A specialist Palliative Care Nurse also visited the home on three occasions between 18th January and 18th March (i.e. in the days just prior to Dyanne's death). There were no issues noted.

16.11 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?

16.11.1 All medical professionals note that during their contacts with her, Dyanne had full capacity to make decisions about her care and treatment. Her wishes were respected. For example, when she declined to attend hospital

during the attendance of an ambulance crew. The paramedics advised Dyanne she should go with them to hospital due to the seriousness of her condition. They referred through to The Christie from the scene. The Christie staff also advised Dyanne to attend her local hospital. But she declined and preferred to remain at home. Her wishes were respected.

16.11.2 Capacity to make such decisions is assumed within the guidance of the Mental Capacity Act 2005. No records made by the frontline practitioners giving care to Dyanne suggest that she did not retain such capacity, even when she was taking pain relief.

16.11.3 During some telephone consultations with the GP Practice, it appears Dyanne, as the patient, was not consulted directly. Her husband rang on her behalf. However, Dyanne was very ill and suffering pain and discomfort. There is no evidence of any ulterior motive by Graham other than to ensure his wife was receiving the most appropriate care. Also, the couple had been with the same GP practice for over 30 years and so it may be that staff had knowledge of both Dyanne's condition and the relationship history between Dyanne and Graham.

16.11.4 MFT District Nursing Team notes also confirm that Dyanne was offered a hospital bed at home, as it may have afforded her greater comfort. Dyanne declined this and stated to nurses that she preferred to stay in the marital bed with her husband.

16.11.5 Dyanne did express her concerns to medical staff that her husband was unable to accompany her inside the hospital for chemotherapy and other appointments. These restrictions (imposed due to the Covid-19 pandemic) meant that Graham was worried about his wife but also that Dyanne became more anxious as her husband wasn't with her for support.

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

16.12.1 At a palliative care home visit, the nurse assessed issues relating to end of life care. She noted the stresses on the family. The notes state 'discussions were within the usual parameters'. This suggests nothing out of the ordinary was observed.

16.12.2 Similarly, the GP notes have no concerns recorded. Graham had raised queries about diet or difficulty in swallowing. Clearly, he was trying to give the best homecare possible to his wife. She was increasingly dependent on his help but this does not illustrate a change in their relationship.

16.12.3 The Christie (specialist cancer centre) noted in November 2020 that Graham was struggling psychologically and offered a referral to the Psychiatric Team which he declined. Again, considerations and observations were within the usual parameters of what was a very distressful time for the patient and her family.

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

16.13.1 The couple were very active prior to Dyanne's illness. They enjoyed a number of hobbies together, however, both had retired so there were no unplanned changes in employment, or financially. Clearly their social life and hobbies were drastically affected. The sudden nature of Dyanne's terminal diagnosis and deterioration was exacerbated by their isolation from traditional support networks of family and friends due to the Covid-19 lockdowns imposed from October 2020.

16.13.2 Medical notes indicate Dyanne's decline in health was rapid. Symptom management was a struggle. There were also other worries recorded linked to fear of bringing the Covid virus into the home. Graham and Dyanne were particularly fearful of this as it would mean Dyanne going into hospital and Graham being unable to visit her. Diagnosis of a terminal illness can lead to suicidal thoughts and the data shows suicides were greater in those with a terminal illness.[1]

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

16.14.1 The perpetrator was of previous good character and had no convictions for any type of offending.

16.14.2 Graham was acquitted of murder at trial in July 2022. The court accepted his defence of a suicide pact. He was therefore convicted of manslaughter.

16.14.3 Graham did express concerns that the GP Practice were not proactive in contacting him or his wife and this caused them both frustrations.

[1] Suicides among people diagnosed with severe health conditions England 2017 to 2020 (ONS April2022)

16.15 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?

16.15.1 All the protected characteristics have been considered. The couple were white European and born in the UK. Other than medical agencies, they did not access any other statutory services. They were married. Neither was registered with a disability. Dyanne did become very frail and suffered a great deal of pain and discomfort due to her terminal illness, though she was not registered with any disability. Her palliative care plan was tailored to her condition.

16.16 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?

16.16.1 NWAS had no significant changes to services. Their staff received guidance on social distancing and had additional personal protective equipment, but the service remained 24/7.

16.16.2 MFT amended some of its proactive appointment schedule during the pandemic. However, cancer care remained in place and Dyanne continued to receive face to face interactions. There was a strict testing and hospital visitation policy, but the treatment offered to Dyanne was not affected by this.

16.16.3 Primary Care continued with similar restrictions to those in place at MFT. There were face to face appointments when necessary, but many appointments switched to online or telephone. (See Royal College of GPs advice/ guidance on covid-19).

Section 17: Conclusions and Lessons Learned.

17.1 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.

17.2 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.

17.3 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.[2]

17.4 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. [3]

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

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

[3] 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.

17.6 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.

17.7 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.

17.8 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.

17.9 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".

17.10 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.

Section 18: Recommendations

18.1 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.

References

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home Office 2016)

Domestic Homicide Reviews ‘Key findings from analysis of domestic homicide reviews’ (Home Office 2016)

‘The Social Worker’s Guide to The Care Act 2014.’ (Pete Feldon 2017)

‘A Practical Guide to the Mental Capacity Act 2005.’ (Matthew Graham and Jakki Cowley 2015).

PEEL Inspections into domestic abuse (HMICFRS November 2017)

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

Consultation on Public Interest guidance for suicide pact and ‘mercy killing’ type cases (Crown Prosecution Service public consultation January 2022)

Code for Crown Prosecutors (revised) (Crown Prosecution Service guidelines October 2018)

Dignitas website (assisted suicide) 2022

Suicides among people diagnosed with severe health conditions England 2017 to 2020 (ONS April2022)

Dignity in Dying website

Untangling the concept of coercive control (Walby & Towers 2018)

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