SAFER PEMBROKESHIRE

PEMBROKESHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

REPORT INTO THE DEATH OF JUNE in FEBRUARY 2021

Report produced by Rhian Bowen-Davies
Independent Chair and Author

February 2022

A note to June's Family

June was a mum, a grandmother and a sister and will be missed by those of you who knew and loved her.

The Panel offers its sincere condolences and acknowledges that the review process has caused you upset and distress. We further recognise that the circumstances considered in the Review may continue to impact upon your day to day lives.

Whilst respecting your decision not to participate in the review the Panel are saddened not to have heard your memories of June which would have helped us to better understand her as a person and how she lived her life.

This review aims to offer a detailed and balanced account of events leading to her death and identify opportunities for learning.

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SECTION ONE – CONTEXT FOR THE DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to June, a resident of Pembrokeshire prior to her death in February 2021.

1.2 To provide anonymity, pseudonyms have been used in this report for June and Peter. Without the family's involvement to advise the Panel on this matter the Panel have chosen the pseudonyms.

1.3 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers in accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.4 The key purpose for undertaking Domestic Homicide Reviews 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 again.

2. Circumstances of the Review

2.1 June was 71 years of age at the time of her death in February 2021. She had been married to Peter, 81 years of age for 51 years. They had four adult children and six grandchildren.

2.2 Their adult children lived in England and abroad and there was very little contact between them and their parents.

2.3 June and Peter had lived in Dorset prior to moving to West Wales. Records on the Welsh Demographics Service indicate that they had moved to Wales around 1992 and moved between Carmarthenshire and Pembrokeshire until renting the cottage in Pembrokeshire in 2009.

2.4 The two-bedroom stone cottage was located in a very isolated and rural area with only one farm in sight, which belonged to the landlord. They ended their tenancy in 2012 but returned in May 2013 and remained tenants there until February 2021.

2.5 In mid-February 2021, officers from Dyfed Powys Police attended at June and Peter's address in response to a call originating from South Wales Police. A letter had been posted by Peter to the regional Royal Mail Sorting Office with the following information written in red and underlined on the envelope *Ring 999 and inform the police that this envelope contains admission of a recent murder + suicide*.

The letter within the envelope written and signed by Peter read

I Peter…….admit that I murdered my wife June this evening/night, I intend and have made preparations to hang myself.

Although we have both found life difficult in recent years and fear being alone one day she is entirely innocent of ending her life intentions. We are devoted to each other and she was always a perfect wife. I took it upon myself to kill her to spare her from the distress such as my mother and her mother and sister had to endure in later life.

The letter also contained detailed directions to the cottage.

2.6 On attending at the property officers entered and located the bodies of June and Peter, both deceased. June was found lying on the sofa in the living area of the property, a bag over her head, which was tied with a ligature. An open bible and rosary beads were found on her chest and her feet were tied. Peter was found hanging by a rope from the banister of the mezzanine floor overlooking the living area.

2.7 The Home Office Pathologist concluded that June had died as a result of a combination of suffocation and strangulation and that Peter had taken his own life by hanging.

2.8 An inquest into the deaths was opened by the Coroner for Pembrokeshire and Carmarthenshire on the 8th April 2021. At the hearing on the 23rd September 2021 the Coroner recorded June's death as an unlawful killing.

2.9 On the 10th March 2021, Dyfed Powys Police notified Pembrokeshire Community Safety Partnership of this case.

2.10 On the 1st April 2021, Pembrokeshire Community Safety Partnership convened a meeting, which was attended by representatives of Pembrokeshire County Council, Hywel Dda University Health Board, Dyfed Powys Police, National Probation Service and Mid and West Wales Fire and Rescue Service. It was decided by partners at the meeting that the criteria for a Domestic Homicide Review had been met and partners further agreed to appoint Rhian Bowen-Davies as the Independent Chair of the Review.

2.11 Agencies were requested to secure their files on the 1st April 2021.

2.12 The Home Office was notified of the decision of the Pembrokeshire Community Safety Partnership on the 6th April 2021.

2.13 A further meeting of statutory partners was convened on the 22nd April 2021 to consider the scope of the review and the first meeting of the Review Panel took place on the 17th June 2021.

2.14 The Overview Report, Executive Summary and Action Plan was presented to the Pembrokeshire Community Safety Partnership on the 29th April 2022. The

delay in completing the review was as a result of the Chair becoming unwell in autumn 2021 and the impact of this on her ability to complete the review in line with the intended timescale.

3. Confidentiality and Dissemination of the Report

3.1 All information discussed at Domestic Homicide Review Panels is *strictly confidential* and must not be disclosed to third parties without discussion and agreement with the CSP/DHR Panel Chair. The disclosure of information outside these meetings (beyond that which is agreed) would be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

3.2 Appropriate confidentiality agreements were signed by all Panel Members and individuals participating in the review.

3.3 All documentation was marked CONFIDENTIAL DRAFT- NOT TO BE DISCLOSED WITHOUT THE CONSENT OF PEMBROKESHIRE CSP.

3.4 All agencies were asked to adhere to their Data Protection procedures including the security of electronic data.

3.5 The Panel considered the Overview Report and Executive Summary in line with the requirements of the Home Office Guidance at meetings on the 16th December and 18th February 2022 and, following agreement, provided a copy of these documents and the Action Plan to the Safer Pembrokeshire Community Safety Partnership for scrutiny and sign off.

3.6 Until it was approved for publication by the Home Office Quality Assurance Panel it was in its final draft stage and remains confidential.

3.7 At the point of the report's completion the only people with whom it was shared were the members of the Panel. No family members had received a copy of the draft report (see Section 7 below for further detail).

3.8 On receiving clearance from the Home Office Quality Assurance Panel this report, alongside the Executive Summary and the Action Plan will be shared with participating agencies as final documents and be published on the Pembrokeshire County Council website in line with Home Office Guidance. The documents will also be shared with Mid and West Wales Safeguarding Board, the Regional Violence against Women, Domestic Abuse and Sexual Violence Partnership, the Police and Crime Commissioner for Dyfed Powys, Wales Safeguarding Repository and the Domestic Abuse Commissioner for England and Wales.

4. Demographics

4.1 This information is provided as context relevant to the circumstances of the case.

4.2 June lived in a remote and isolated cottage in Pembrokeshire and it was here in mid-February 2021 that she was found deceased.

4.3 Pembrokeshire is a county in the southwest of Wales bordered by Carmarthenshire to the east, Ceredigion to the northeast and the Irish Sea. The latest population estimate for Pembrokeshire is approximately 124,000, which increases over the summer months due to tourism. The age profile of the population shows significantly fewer 20-39 year olds and more people over the age of 55 than the UK as a whole. It is predicted that the 65+ age group will increase in Pembrokeshire from 25% of the total population in 2015 to 34% by 2039 and it is estimated that 10% of the 65+ age group will require care. The population projection for Pembrokeshire is consistent with the view that there is an ageing population where people are living longer.

4.4 Pembrokeshire is predominately rural in nature and is sparsely populated with a handful of urban towns. This means that people are likely to live further away from public services and other amenities. The principal settlements in the County are Haverfordwest, Milford Haven, Pembroke Dock, Pembroke, Fishguard / Goodwick, and Tenby and together these settlements are home to around 44% of the County's population. Smaller significant settlements such as Neyland, Newport, St Dogmaels, Narberth, Johnston, Kilgetty and Saundersfoot are home to a further 12% of the County's population. The remainder of the population (around 44%) live in smaller settlements and the countryside.

4.5 Pembrokeshire is part of the Mid and West Wales region. The region comprises four local authority areas; Carmarthenshire, Ceredigion, Pembrokeshire and Powys, two local health boards; Hywel Dda University Health Board and Powys Teaching Health Board and Mid and West Wales Fire and Rescue Service. It is these authorities that are required, by the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 to jointly publish a Domestic Abuse, Sexual Violence and Violence against Women strategy. The strategy, published in November 2018, outlines the region's priorities for tackling domestic abuse, sexual violence and violence against women and will be reviewed in 2022.

4.6 The Mid and West Wales region has the same geographical footprint as Dyfed Powys Police and the Police and Crime Commissioner. Other key partners in tackling domestic abuse, sexual violence and violence against women also operate on the Mid and West Wales footprint e.g. National Probation Service, Welsh Ambulance Service NHS Trust, Public Health Wales, Housing providers, the Specialist Domestic Abuse, Sexual Violence and Violence against Women services and the wider third sector.

4.7 In 2020/21, Dyfed Powys Police recorded

- 9563 incidents of domestic abuse
- 337 rapes and 818 other sexual offences

- 6745 stalking / harassment crimes

4.8 During the period April 2020 – March 2021 547 cases were discussed in the MARAC meetings in the region, 7% of these were repeat referrals.

4.9 This is the third Domestic Homicide Review undertaken by Pembrokeshire Community Safety Partnership and consideration has been given to the findings and recommendations of the previous reviews. There are another 4 DHRs ongoing in the Mid and West Wales region at the time of writing this report, 3 of these reviewing the deaths of older women.

5. Terms of Reference

5.1 Terms of Reference were drafted by the Chair following the meeting in April 2021 and agreed by the Review Panel in June 2021. It was agreed at this meeting that any family members who wished to participate in the review would be provided with the draft terms of reference to consider and feedback any amendments to the Panel.

5.2 Due to the decision of family members not to participate in the review no amendments were made to the document.

5.3 The Terms of Reference were reviewed by the Panel at their meeting in August 2021 to ensure continued relevance.

5.4 A copy of the Terms of Reference is included below in italics for reference:

Purpose of the Review

The purpose of the DHR is to:

a) 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;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

Principles

The review will be conducted in line with the following principles;

i) An inquisitive, diligent and thorough effort to learn from the past to make the future safer;
ii) With honesty and humility;
iii) With professional curiosity and an open mind – going beyond focusing on conduct of individuals and whether procedure was followed to evaluate whether policy / procedure was sound;
iv) The review will be situated in June's home, family and community, with the narrative articulating life through her eyes; enabling the reviewers to understand her reality;
v) Understanding the context and environment in which professionals made decisions and took (or did not take) actions e.g. organisational culture, training, supervision and leadership;
vi) Status of the family as integral to the review;
vii) A willingness to learn and to place this learning in the "here and now".

Objectives of the Review

- *To better understand the life, relationships and context for June's death*
- *To identify and examine patterns of behaviours in particular coercive and controlling behaviours as they relate to June and Peter*
- *To examine the actions/responses of relevant agencies, services and professionals to both June and Peter within the agreed timeline*
- *To examine the experiences of older people and particularly those living in rural communities of accessing information and services during the Covid 19 pandemic*
- *To ensure that the family and friends of June are given the opportunity to make a meaningful and effective contribution to this review and are offered and provided with appropriate specialist support to enable them to be an integral part of the process*
- *To produce a chronology and initial summary, which will seek to identify any actions already taken or changes implemented.*
- *To consider relevant research and lessons learnt from previous DHR's where there are similar characteristics*
- *To consider potential gaps in service provision, alongside potential barriers to accessing services*
- *To produce a comprehensive, honest and balanced analysis of circumstances to inform organisational / agency learning and influence change.*

Focus of the Review

- *To consider experiences of domestic abuse, in particular coercive and controlling behaviours as they relate to June and Peter*

- *To identify which agencies/organisations had involvement with June and Peter from the time they moved to Pembrokeshire in May 2013 to February 2021. If deemed necessary, information outside of this timeline may be requested from relevant organisations*
- *To review agencies/organisations involvement during this period and consider the appropriateness of responses and any services provided to June and Peter*
- *To review the extent to which agencies/professionals worked together when responding to the needs and circumstances of the subjects of this review*
- *To determine whether decisions and actions in this case comply with the policy and procedures of named services at the time and how these may have changed since the period in question; ensuring that learning is considered in the "here and now"*
- *To examine the impact of Covid-19 on the daily lives of June and Peter*
- *To examine the impact of Covid 19 on the availability of information and responses, reach and accessibility of services to older people in rural communities*
- *To consider the age and gender of June as factors throughout the review*
- *To consider whether, and to what extent Mental Health contributed to the circumstances leading to the deaths of June and Peter*
- *To provide effective, meaningful opportunities for the family and friends of June to play an integral part in the review. This engagement will be facilitated by the Chair and include offers of specialist advocacy support.*

Membership of the Review Panel

It is the responsibility of the Panel to provide rigorous oversight and challenge to the information that is presented and to make an honest, diligent and thorough effort to learn from the past.

The following representatives have been agreed as Members of the Review Panel

Rhian Bowen-Davies	*Chair*
Sinéad Henehan	*Pembrokeshire County Council Community Safety, Poverty and Regeneration Manager*
Darren Mutter	*Pembrokeshire County Council representative (Head of Children's Services and Safeguarding)*
Superintendent Anthony Evans	*Area Commander, Dyfed Powys Police*
Mandy Nichols-Davies	*Head of Safeguarding, Hywel Dda University Health Board*
Rachel Munkley	*Lead VAWDASV and Safeguarding Practitioner, Hywel Dda University Health Board*
Lynne Richards	*Corporate Partnership Officer, Pembrokeshire County Council*
Nicola Brown	*National Probation Service*
Diana Harris	*Mid and West Wales Welsh Fire and Rescue Service*

Elize Freeman	*Service Development and Training Lead, Dewis Choice (Specialist Domestic Abuse Service for Older People)*
Natalie Hancock	*Regional Adviser Violence against Women, Domestic Abuse and Sexual Violence*
Dr Catherine Burrell	*Associate Medical Director, Hywel Dda University Health Board (Representing Primary Care)*
Peter Gills	*Service Manager, Adult Mental Health, Hywel Dda University Health Board*
Sian Bell	*Information and Advice Manager, Age Cymru Dyfed*

The membership has been agreed to ensure that relevant expertise in relation to the particular circumstances of this case is represented. Should further expert advice be required it is agreed that this will be sought, as appropriate, by the Chair.

Requests for Information Managements Reports

Information Management Reports (IMR's) were requested from the following organisations;

- *Dyfed Powys Police*
- *Age Cymru Dyfed*
- *Pembrokeshire County Council*
- *Hywel Dda University Health Board*
- *Swansea Bay University Health Board*
- *Wales Ambulance Service Trust*
- *National Probation Service*
- *Mid and West Wales Fire and Rescue Service*
- *Live Fear Free, the All Wales Violence against Women, Domestic Abuse and Sexual Violence Helpline*
- *Pobl Housing Association (joint provider of the Independent Domestic Violence Adviser Service for Mid and West Wales)*
- *Hafan Cymru (joint provider of Independent Domestic Violence Adviser Service for Mid and West Wales)*
- *West Wales Domestic Abuse Service*
- *Carmarthenshire Domestic Abuse Service*
- *Threshold Domestic Abuse Service*
- *Calan Domestic Abuse Service*
- *Dewis Choice*
- *Dorset County Council*
- *Dorset Police*
- *Dorset Healthcare Foundation Trust*
- *Christchurch Medical Practice*
- *The You Project – Dorset Domestic Abuse Service*
- *Department for Work and Pensions*

The IMRs will be completed in accordance with Home Office Guidance and the expectations of the Chair.

If, during the course of the review the Panel identify individuals / organisations outside of those listed above who should be contacted, it will be for the Panel to agree who is best placed to make this contact on their behalf.

Scope of the Review

The review will consider events and agency involvement with June and Peter from the time they started their second tenancy at the cottage in May 2013 to the date of June's death in February 2021.

If deemed necessary, information outside of this timeline may be requested from relevant organisation.

Parallel Reviews

There are no parallel reviews into the deaths of June and Peter.

An inquest into the deaths was opened by the Coroner for Pembrokeshire and Carmarthenshire on the 8th April 2021. At a hearing on the 23rd September 2021 the Coroner recorded June's death as an unlawful killing.

Timescale, Report Author and Final Report

- *It is our intention that this Review takes no longer than 6 months to complete from the 22nd April 2021 (first Panel meeting with the Chair).*
- *The DHR will be chaired by Rhian Bowen-Davies who will also be the Report Author.*
- *The Report produced will be an honest, open and comprehensive analysis of circumstances to inform learning and influence change.*
- *In accordance with Home Office guidance, any recommendations for improvement will be outcome focussed and SMART.*
- *The Review Panel will consider and agree any learning points to be incorporated into the final report and action plan. Where actions or learning points requiring immediate implementation are identified these will be highlighted to the CSP Chair and shared without delay, prior to Home Office approval of the Report.*
- *The Chair of the CSP will send the final report and action plan to relevant agencies for final comment before sign-off and submission to Home Office. The Chair of the CSP will provide a copy of the overview report, executive summary and action plan to the senior manager of each participating agency following HO approval.*
- *The Chair of the CSP, in agreement with the Review Chair will send a copy of the final report to all relevant forums in order to share learning and, where appropriate shape priorities and programmes of work e.g. Mid and West Wales Safeguarding Board, Violence against Women, Domestic Abuse and Sexual Violence Strategic Group, Pembrokeshire Safeguarding Network.*

- *The Chair of the CSP will publish an electronic copy of the overview report and executive summary on the local CSP web page.*
- *Subject to the recommendations of the Panel, the Chair of the CSP will hold a learning event.*
- *The CSP will monitor implementation of the Action Plan in accordance with the guidance.*

Confidentiality

All information discussed at Domestic Homicide Review Panels is STRICTLY CONFIDENTIAL and must not be disclosed to third parties without discussion and agreement with the CSP/DHR Panel Chair. The disclosure of information outside these meetings (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

All documentation is to be marked CONFIDENTIAL DRAFT- NOT TO BE DISCLOSED WITHOUT THE CONSENT OF PEMBROKESHIRE CSP.

All agencies are asked to adhere to their own Data Protection procedures, which include security of electronic data.

Following completion of the review, the Chair will produce a draft overview report, which is presented with the recommendations action plan to the Community Safety Partnership (CSP). At the time that the review is presented to the CSP, it is in its final draft stage and remains confidential until it has been approved for publication by the Home Office Quality Assurance Panel.

Appropriate confidentiality agreements will be signed by all members of the Panel and individuals participating in the review.

Legal advice and costs

Each statutory agency should inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

Should the Independent Chair, Chair of the Safer Pembrokeshire Community Safety Partnership or the Review Panel require legal advice then Safer Pembrokeshire Community Safety Partnership will be the first point of contact.

Media and communication

The Chair of the Safer Pembrokeshire Community Safety Partnership will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. On completion of the review, a discussion will be held between the Chair of the CSP and Chair of the review in response to media requests on a case-by-case basis.

Revision of the Terms of Reference

The Terms of Reference may need to be revised and agreed by the Review Panel as the DHR progresses and for this purpose they will be considered at each Panel meeting to ensure continued relevance.

6. Methodology

6.1 Upon her appointment, the Chair met with the Senior Investigating Officer (SIO) from Dyfed Powys Police for an initial briefing and requested a further briefing for Panel members at their first meeting in June 2021, which was provided by both the Senior and Deputy Investigating Officer.

6.2 The Chair met with Deputy Senior Investigating Officer and the Family Liaison Officer in May 2021 to gather further information and determine how best to contact family members to invite them to participate in the review.

6.3 Contact with members of June's family was made in May 2021 and this is detailed further in Section 7 below.

6.4 The person responsible for June's death, her husband Peter was also found deceased at the property that they shared in February 2021 and therefore the review did not have an opportunity to speak with him to determine whether interventions or services could have been offered to prevent his actions.

6.5 Requests for Individual Management Reviews and chronologies were made to agencies listed in paragraph 9.2 following the first Panel meeting in June 2021. The chronologies were then collated into one overarching chronology.

6.6 Panel members had the opportunity to scrutinise all the information submitted at meetings in August and December 2021 and February 2022 where collectively, challenges and requests for further information / clarification were collated and learning, good practice and recommendations identified.

6.7 The Chair conducted meetings with the following as part of the review;

- HM Coroner for Carmarthenshire and Pembrokeshire:
- Members of the Dyfed Powys Police investigation team;
- Dyfed Powys Police Family Liaison Officer;
- Practice Manager and GP from the Practice that June and Peter were registered;
- Representatives of the 2 Dental Practices that June and Peter were registered with;
- Communications Manager for Hywel Dda University Health Board;
- Landlord of the cottage rented by June and Peter.

6.8 The Chair also wrote to the Letting Agent responsible for the management of the cottage. On receiving no response, she contacted the Letting Agent and spoke to

the Property Manager on the phone who did not wish to discuss the matter further.

6.9 As part of the review the Chair visited the location of the cottage that June had lived in with Peter and also visited the locations that they had visited leading up to their deaths.

6.10 The Chair accessed a range of information that formed part of the police investigation including phone and bank records, witness statements, timelines and CCTV footage to build an understanding of how June and Peter had lived their lives.

6.11 The Chair was also able to view June's diary entries for January and February 2021.

6.12 She also reviewed Welsh Government Guidance provided to Health Boards and General Practices and information provided to residents in Pembrokeshire in response to the Covid pandemic.

6.13 The Chair, who is also the author, prepared the draft report, which was shared with Panel members at meetings in December 2021 and February 2022. Family members were contacted in March 2022 and offered the opportunity to read the report and provide feedback. June's sister was the only family member to respond to the Chair's offer and whilst the Chair provided further details to enable her to share the report with June's sister she received no response to her correspondence up to the date that the report was presented to the Community Safety Partnership.

6.14 The draft overview report, executive summary and action plan was presented to the Safer Pembrokeshire Community Safety Partnership at their meeting on the 29th April 2022.

7. Involvement of Family and Friends

7.1 No contact had been made with the family of June regarding the DHR prior to the appointment of the Chair. At the first meeting of the Panel, the Chair outlined her expectations that family and friends would be an integral part of this review and given equal status to the agencies who were participating. This is reflected in the objectives of the review as outlined in the Terms of Reference.

7.2 It is the Chair and Panel's view June's family knew her best and were best placed to help the Panel understand her as a person and provide an insight into how she lived her life.

7.3 Before contacting the family, the Chair met with the Senior and Deputy Investigating Officer and the Family Liaison Officer who had supported the family members through the criminal investigation.

7.4 At the beginning of May 2021, the Chair, supported by the Family Liaison Officer, wrote to June's four adult children, her sister and Peter's brother. Whilst one of the adult children had been the single point of contact for the investigation, the Chair wished to contact all of the children with the information and the offer to participate in the review.

7.5 The letter, which was sent via email by the Family Liaison Officer:

- Offered the Chair's condolences;
- Acknowledged that the family had not told about the potential for a review or provided with any information relating to the review;
- Explained the DHR process;
- Offered the opportunity to participate in the review through various methods (in writing, via a recording, telephone conversation or a meeting with the Chair / Panel members);
- Outlined the timeline for the review;
- Explained that the review would produce a final report and executive summary;
- Provided information relating to specialist advocacy and the offer to facilitate a referral (AAFDA information leaflets, website and contact details were provided);
- Included the Home Office information leaflet and a link to the statutory guidance;
- Outlined the scope of the review and an opportunity to comment /feedback on the initial terms of reference;
- Provided contact details for the Chair with an invitation to contact directly.

7.6 The single point of contact for the adult children responded to the Family Liaison Officer stating that none of them wished to participate in the review.

7.7 On receipt of this response, the Chair wrote to all of the adult children stating that she respected their decision not to participate but she was disappointed that their

views and contributions would be missing from the review. She further explained that she would contact them again when the draft report was completed to offer the opportunity to review and comment and further provided her direct contact details should they wish to contact her.

7.8 Having received no response from June's sister to the initial email sent by the Family Liaison Officer the Chair send a second letter at the end of May 2021 to which there was no response. This letter also stated that the Chair would contact her at the end of the review to offer the opportunity to review the report and provide feedback.

7.9 An initial letter was also sent to Peter's brother who had been noted as the next of kin in the letters found by Police at the cottage. His response to the Chair outlined his disapproval of the decision to conduct a review which he described as 'ill-judged and inappropriate' in light of the fact that the circumstances of June's death were yet to be determined. He further stated that he did not wish to participate in the review.

7.10 In her response to this letter the Chair referred to the Home Office Guidance which requires reviews to be conducted in cases of homicide and suicide and further provided assurances that she would work alongside the Coroner throughout the review. As in other correspondence with family members the Chair stated that she would contact him again when the draft report was completed to offer the opportunity to review and comment.

7.11 Whilst the decision of family members to not participate in the review is both understandable and respected it is also regrettable in the fact that their memories of their mum and sister and their views about what happened are missing from the review. Whilst the Chair has been able to view the statements provided to the Police the review is undoubtedly poorer without the contribution of those who knew her best.

7.12 In March 2022, the Chair wrote to June's adult children and her sister informing them that she had completed the review and offering them the opportunity to comment on the draft report. June's sister responded and the Chair provided further details to facilitate the sharing of the report with her. Unfortunately, the Chair did not receive any further correspondence from June's sister prior to the draft report being agreed by the Community Safety Partnership on the 28th April 2022.

7.13 Despite attempts by Dyfed Powys Police and the Chair, the Panel has been unable to identify any friends or associates of June or of June and Peter as a couple. There were no references to any persons other than family members in June's diary.

7.14 The Chair spoke to the Landlord of the cottage in which June and Peter lived who was also their nearest neighbour. He describes the couple as *'very private…kept themselves to themselves….didn't do anything with anyone'*. The farm in which the landlord lives overlooks the cottage and in the time June and Peter lived there the landlord commented that he never knew of anyone visiting.

He states that he very rarely saw the couple and that it had been approximately five years since he saw them in person. He recalled one occasion when he saw an ambulance at the cottage and went there to check if everything was ok. He recalls that Peter had slipped on steps and that June was concerned that she may have to drive as she hadn't driven for a while. The landlord describes her as very quiet and that this was the only time he had spoken to her in the time that they had lived in the cottage. The landlord stated that he wasn't aware of anyone who knew the couple and that they didn't go to the local village.

7.15 The landlord indicated that Peter had a good relationship with the Property Manager at the Letting Agency and the chair wrote to the Letting Agency asking for a discussion with him. On receiving no response, she contacted the Letting Agent and spoke to the Property Manager who did not wish to discuss the matter further.

7.16 During the investigation, Dyfed Powys Police had spoken to local shop owners and neighbours but nobody had anything to say about the couple.

7.17 It has saddened the Panel that their understanding of June as a person, her life and the circumstances leading to her death has come only from her diary entries and statements provided to the police as part of their investigation rather than anyone who knew her and this is explored further in the analysis section of this report.

8. Review Panel

8.1 In accordance with statutory guidance, a Review Panel was established. It is the responsibility of the Panel to provide rigorous oversight and challenge to the information that is presented and to make an honest, diligent and thorough effort to learn from the past.

8.2 Membership of the Panel was agreed to ensure that appropriate and relevant expertise in relation to the particular circumstances of this case was represented. It was also agreed that should further expert advice be required during the review that this would be sought, as appropriate, by the Chair.

8.3 Panel membership included agencies with specialist knowledge and expertise relevant to this case including Age Cymru Dyfed who provide information and support services for older people across the County. Also on the Panel was a representative from Dewis Choice. The Dewis Choice Project is based at the Centre for Age, Gender and Social Justice in Aberystwyth. Its aim is to drive much-needed change for all older "victim-survivors", including LGBTQ people and those dealing with domestic abuse and dementia. The initiative has conducted a five-year longitudinal study of 120 later-life domestic abuse cases, trained over 8,000 frontline professionals and, together with "victim-survivors", it has designed the only one-stop holistic service in the UK for people aged 60 and over who have experienced abuse.

8.4 An invitation was offered to Pembrokeshire Association of Voluntary Services (PAVS) to be part of the Review Panel. The Chair met with the Chief Officer of

PAVS to provide an overview of the DHR process and responsibility of Panel members. Whilst the Chief Executive did not feel that it was appropriate for the organisation to be represented on the Panel, the Chair agreed to share the learning and recommendations from the Review with the Chief Executive to inform policy and practice within the county.

8.5 All members of the Panel were independent of the case itself and did not hold direct line management responsibilities for individuals involved in the case.

8.6 Members of the Review Panel are listed in the Terms of Reference above.

8.7 Business support for the meetings and the review process as a whole was provided by the Corporate Partnerships Officer, Pembrokeshire County Council.

8.8 The Review Panel met on 4 occasions in June, August and December 2021 and February 2022 before the draft report, executive summary and action plan was presented to the Pembrokeshire Community Safety Partnership in April 2022.

9. Contributors to the Review

9.1 The Chair and Panel sought to maximise the contributions of all relevant agencies throughout the review. Contributions were sought through requests for Individual Management Reviews (IMR) and chronologies.

9.2 Individual Management Reviews are a crucial first step to establishing an understanding of timescales, the course of events and responses of agencies. The IMRs requested are detailed below along with the response received:

IMR received	Nil return	Information Report
Department of Work and Pensions	Age Cymru Dyfed	
Dorset Police	Carmarthenshire Domestic Abuse Services	Christchurch Medical Centre
Dyfed Powys Police	Calan Domestic Abuse Service	Dorset Community Safety Partnership
Hywel Dda University Health Board which included primary and secondary care	Dewis Choice – specialist service for older people experiencing domestic abuse	
Swansea Bay University Health Board	Dorset Healthcare Foundation Trust	Pembrokeshire County Council Waste Disposal Team
Welsh Ambulance Service NHS Trust	Hafan Cymru (provider of IDVA service)	Wales and West Housing Association
	Live Fear Free – Welsh Government funded National Helpline	
	Mid and West Wales Fire and Rescue Service	

	National Probation Service	
	Pembrokeshire County Council	
	Pobl – provider of IDVA service in Pembrokeshire	
	The You Trust – Domestic abuse service Dorset	
	Threshold Domestic Abuse Service	
	West Wales Domestic Abuse Service	

9.3 As information was submitted to the review, additional organisations, outside of those originally considered were identified and IMRs requested. These included the Department of Work and Pensions, the Dorset based agencies listed above and accommodation providers Wales and West Housing Association and Anchor Care Homes.

9.4 The request for information from Dorset based organisations was made via the Dorset Community Safety Partnership. The Panel knew that June and Peter had returned to the area for a period 2012 and 2013 but were also aware that it was here that they lived prior to moving to Wales. Despite this, only very limited information was shared with the Review in particular from Christchurch Medical Centre. It was due to the diligence of the Safeguarding Lead for Hywel Dda University Health Board that relevant and appropriate health related information was provided to the Panel relating to the period that June had lived in Dorset rather than the Dorset based organisations.

9.5 Each organisation was asked to provide details for a Single Point of Contact for the purpose of the DHR.

9.6 A written briefing and template for responses were provided to all organisations asked to complete an IMR. These documents were based on Appendix Two within the Home Office Guidance document. A request for a chronology of involvement with subjects of the review was made to be submitted alongside their IMR, which was then collated into an overarching chronology.

9.7 The Chair outlined her expectations for the completion of IMRs in the first meeting of the Panel in accordance with the aims within the statutory guidance; in that IMRs should

a) allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards

b) identify how and when those changes or improvements will be brought about.

c) identify examples of good practice within agencies.

9.8 In accordance with Home Office Guidance the Chair stated her expectations in relation to the authors being independent of the individuals subject to the review and their families, not having line management of the case and that IMRs would be quality assured by sufficiently senior managers. Both of these elements were required to be signed off in the IMR return.

9.9 The Chair also requested reference to source documents within the IMRs to enable her and the Panel to rigorously scrutinise the information provided, seek clarification and challenge where appropriate.

9.10 An offer of support from the Chair and representative of the Community Safety Partnership was made to all organisations asked to submit an IMR.

9.11 As will be detailed in the Overview and Analysis Section, Health services were the only services who had any contact of note with June and Peter. The quality of the IMR submitted by Hywel Dda University Health Board is noted by the Panel. The IMR provided a thorough analysis of June and Peter's contact with primary and secondary care services both within the scope of the review and outside this timeline and made well-evidenced recommendations to improve practice at a local and national level.

10. Appointment of an independent Chair /Author

10.1 The Home Office Guidance requires the Community Safety Partnership or the Review Panel to
'appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on evidence the review panel decides is relevant'.

10.2 Rhian Bowen-Davies was appointed as Chair/Author in April 2021, due to her combination of practice, leadership and policy-based experience in the field of violence against women, domestic abuse and sexual violence. She was appointed following a request from Safer Pembrokeshire Community Safety Partnership for expressions of interest from suitable applicants.

10.3 In 2015, she was appointed Wales' first National Adviser for tackling Violence against Women, Domestic Abuse and Sexual Violence. Prior to this she held senior management roles within the specialist domestic abuse sector and earlier in her career was an Independent Domestic Violence Adviser and Police Officer.

10.4 As an independent consultant she was commissioned by the regional Violence against Women, Domestic Abuse and Sexual Violence Strategic Group in 2017 to develop the regional strategy for Mid and West Wales. This has given her an invaluable insight into the region and its current responses to violence

against women, domestic abuse and sexual violence from an independent, objective perspective.

10.5 This is the second Domestic Homicide Review that Rhian has chaired in Pembrokeshire, the last one being in 2018/19. Due to the time that has passed since the first review all Panel members apart from the Pembrokeshire County Council representative of the Community Safety Partnership have changed.

10.6 Rhian has no connection and has never been employed by any of the organisations represented on the Panel or the Pembrokeshire Community Safety Partnership.

10.7 Rhian Bowen-Davies has completed both the Home Office and Advocacy After Fatal Domestic Abuse DHR Chair's training.

11. Parallel Reviews

11.1 There are no parallel reviews into the deaths of June and Peter.

11.2 An inquest into the deaths was opened by the Coroner for Pembrokeshire and Carmarthenshire on the 8th April 2021. At the hearing on the 23rd September 2021 the Coroner recorded June's death as an unlawful killing.

11.3 During the review, the Chair met with the Coroner on two occasions. The purpose of these meetings was to ensure that both parties were aware of and understood the respective processes and that relevant information was shared.

11.4 The Chair also attended the Inquest hearing in September 2021.

12. Equality and Diversity

12.1 The Home Office Guidance asks the Review Panel to consider whether there are any specific considerations around equality and diversity issues such as age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. The following protected characteristics were considered as significant factors by the Panel.

Age and Sex

12.2 Age and sex are included within the terms of reference as factors to be considered throughout the review and examined within the report. Some of the evidence as to why we are considering these protected characteristics is listed below:

<u>Sex:</u>

- The majority of victims of domestic homicides (homicides by an ex/partner or family member) from April 2013 to March 2016 were female (70%,), with 30% of victims being male. This contrasts with victims of non-domestic homicides, where the majority of victims were male (88%) and 12% of victims were female. (ONS, 2017)
- The United Nations defines gender-based violence in the following way: *The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or*

sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. (CEDAW 1992: para. 6).

- Whilst both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to have experienced sustained physical, psychological or emotional abuse, or violence which results in injury or death.
- There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2017). Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

Age:

- There is sometimes confusion between the experience of domestic abuse in later life and "elder abuse" (a term which encompasses all forms of violence, abuse and neglect experienced by older people). Such confusion can result in victims of abuse falling between the systems which are designed to offer them protection and consequently do not receive appropriate support to help them to stop the abuse or make them safe.
- Globally there is evidence to suggest that older women experience violence and abuse at similar, or in some cases, higher rates compared to younger women.[1]
- The Crime Survey for England and Wales (CSEW) 2017/18 reported that about 139,500 older women and 74,300 older men between the ages of 60-74 experienced domestic abuse in England and Wales. It is only recently that the age limit of the CSEW has been raised to 75 years of age. Until this point, the cap was 59 years of age, effectively making the experiences of people older than 55 years invisible. In 2022, the age limit will be raised again from 74 years of age so that the experiences of all individuals will be included.
- It is estimated that 1 in 6 older people will experience domestic abuse.
- Older people account for around 18% of the population in England and Wales but individuals over the age of 60 account for one in four victims of domestic homicides suggesting a disproportionate risk to older people[2],[3].
- 40% of all homicide-suicides occur in persons over the age of 55. The majority of domestic homicide victims are female (67%) and perpetrators are male (81%).[4] Older people are almost equally as likely to be killed by a

[1] Violence against Older Women End of Project Report, Dr. Hannah Bows, Durham University April 2020

[2] Bows, H. (2019a) 'Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK', *British Journal of Social Work*, *49*(5), 1234-1253.

[3] Domestic Homicide Project Spotlight Briefing 2 Older People; Katie Hoeher, Lis Bates, Phoebe Perry, Thien Trang Nguyen Phan, Angie Whitaker; Vulnerability Knowledge and Practice Programme February 2022

[4] Bows, H. (2019a) 'Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK', *British Journal of Social Work*, *49*(5), 1234-1253.

partner/spouse (46%) as they are their (adult) children or grandchildren (44%).

- Of the cases examined for the Older Victims Spotlight Briefing, February 2022, in all seven homicide-suicides involving older couples between March 2020 and March 2021, the victims were female[5].
- In November 2020, the Femicide Census published an overview of femicides that had occurred between 2009 and 2018. Of the 1425 women murdered 278 were over the age of 60 years of age and 127 of these had experienced extreme violence[6].The census identified 27 so called mercy killings within the homicides of older people, 9 of these where the perpetrator then took his own life.
- A SafeLives Report published in 2016[7] stated that, on average, older victims experience domestic abuse for twice as long as those aged under 61 before seeking help, yet they are hugely under-represented among domestic abuse services. The report found that victims aged 61+ are much more likely to experience abuse from an adult family member than those 60 and under. According to their Insights dataset, 44% of respondents who were 60+ were experiencing abuse from an adult family member, compared to 6% of younger victims.
- A review of 32 Homicide Reviews commissioned by Standing Together Against Domestic Abuse[8] found the following;
  - In many of the domestic homicides the review looked at, the victim and the perpetrators were considered to be carers for one another;
  - These DHRs found that, like the wider public, professionals can also fail to consider domestic abuse because of the victim's age;
- In a Blog by Standing Together entitled 'What Domestic Abuse Reviews tell us about abuse and older people'[9] the following points are made:
  - Too often assumptions about age can mean that, when older people are injured, depressed or display other potential signs of domestic abuse, the cause is assumed to be poor health or other social care need
  - Older survivors may also have less experience of 'self-help' models or disclosing personal circumstances to a stranger
  - Reviews found the victim's age influenced her view of what help was available
- A further review of 84 Domestic Homicide Reviews in London published in 2019 identified 18 cases where the victim was over 58.[10] Analysis of the cases involving older people identified a lack of understanding of domestic abuse in the family context and failings in identifying abuse, assessing risk and referring victims to appropriate support services. The review further highlighted the absence of a dedicated risk assessment for older people, which they conclude, deters agencies from focusing on risk factors in cases involving adult family abuse. It was identified that in many cases friends and

[5] Domestic Homicide Project Spotlight Briefing 2 Older People; Katie Hoeher, Lis Bates, Phoebe Perry, Thien Trang Nguyen Phan, Angie Whitaker; Vulnerability Knowledge and Practice Programme February 2022

[6] https://www.femicidecensus.org/reports/

[7] Safe Later Lives; Older People and Domestic Abuse; safe Lives October 2016

[8] http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf

[9] http://www.safelives.org.uk/practice_blog/what-domestic-homicide-reviews-tell-us-about-abuse-older-people

[10] London Domestic Homicide Case Analysis and review of Local Authority DHR processes October 2019 Bear Montique

family knew what was going on but did not recognise that what was happening constituted abuse and do not know where they could go for help. The review recommended training for practitioners including Police, GPs, Health and Social Care staff to improve identification and responses to older people's experiences of domestic abuse.

- The Welsh Government, alongside the Older People's Commissioner for Wales published information and guidance for professionals on Older People and Domestic Abuse in 2017, which explores the characteristics of domestic abuse experienced by older people, provision of effective responses and barriers to accessing services.
- In 2020, the Older People's Commissioner for Wales published a report 'Leave no one behind' examining Older People's experiences of the first months of the Covid pandemic.[11] Learning in this report includes the challenges that older people experienced in accessing information and services in the shift to digitalisation and the effectiveness of public health messaging. This learning is applied in the analysis section of the report.
- AThe findings in the Older Victim's Spotlight Briefing published in February 2022 suggest that during the pandemic older people were at increased risk of being victims of domestic homicide especially within an intimate partner context with an increase from 9% to 18% of overall homicides.
- In 2021, the Older People's Commissioner for Wales commissioned research into the support available in each Local Authority area in Wales for older people experiencing violence against women, domestic abuse and sexual violence[12].
  - The report concludes that incidents of older people experiencing abuse remain under-reported and under-recorded. The report finds that older people feel less able to access support that is available for a number of reasons, such as unawareness of support services; a perception that support is not available for older generations; financial dependence on the abuser; a sense of shame or embarrassment; perceived lack of entitlement to support: fear of the consequences of reporting abuse; and perceived ageism amongst professionals.
  - The report further concludes that older people living in rural communities face additional barriers and needs in relation to accessing support services for VAWDASV.[13] There are particular challenges for older people such as living in small, close-knit communities where it is difficult to achieve anonymity; limited or lack of public transport; poor internet connections; lack of IT skills; isolation and services being located some distance away. Abuse in rural areas is likely to last about 25% longer than in urban areas and the levels of reporting in such areas is lower when

[11] https://www.olderpeoplewales.com/Libraries/Uploads/Leave_no-one_behind_-_Action_for_an_age-friendly_recovery.sflb.ashx

[12] Report into the Support available in each local authority area in Wales for Older People experiencing Violence against Women, Domestic Abuse and Sexual Violence 2021 (Inside Out Organisational Solutions Dr. Norma Barry and Rhian Bowen-Davies)

[13] Welsh Women's Aid Briefing: Rurality and VAWDASV

compared to reports in urban areas.[14] These challenges are often overlooked in the design and delivery of services.

- The report found that older people's experiences of domestic abuse are likely to have been further exacerbated as a result of the Covid-19 pandemic necessitating many to shield at home resulting in isolation through lack of direct contact with family, friends and support networks.
- The report makes a range of recommendations to Welsh Government, the Older People's Commissioner for Wales, Public Services and the specialist sector including the establishment of a national taskforce to develop a strategic and system wide approach to improving responses to older people who are experiencing abuse in Wales to review policies, strategies and service delivery models to ensure that they take account of and are responsive to the needs of older people, a review of the national training framework and adopting age appropriate assessments of risk.

12.3 Maintaining a focus on these protected characteristics throughout the review has enabled the Panel to consider organisational responses and the availability, gaps and barriers to accessing information and services through these lenses, which are detailed in the analysis section.

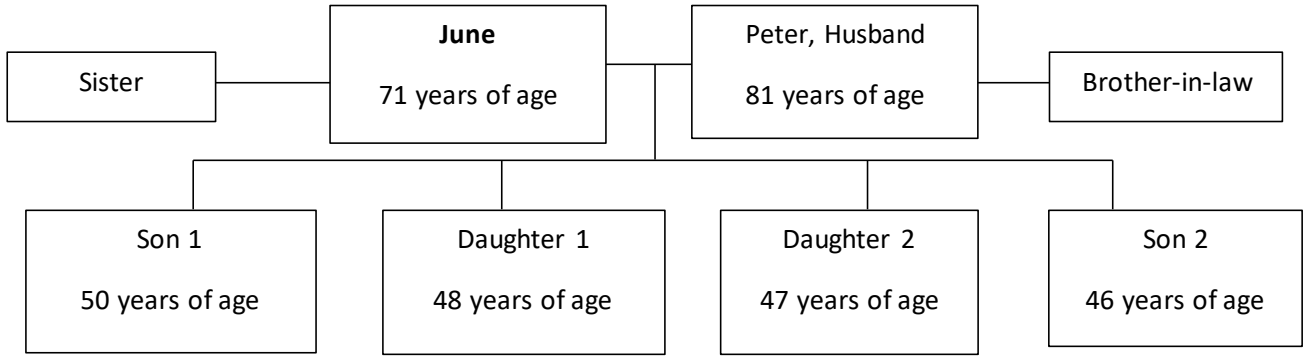
[14] Captive and Controlled, Domestic Abuse in Rural Areas https://www.ruralabuse.co.uk/wpcontent/uploads/2019/07/Domestic-Abuse-in-Rural-Areas-National-Rural-Crime-Network.pdf

SECTION TWO - SUBJECTS OF THE REVIEW

1. June, a British White Female was 71 years of age at the time of her death in February 2021. She had been married to Peter, 81 years of age for 51 years. They had four adult children and six grandchildren.

2. Their adult children lived in England and abroad and there was very little contact between them and their parents.

3. The genogram below illustrates the familial relationships in relation to June at the time of her death in February 2021;



4. June's sister told police as part of the investigation that, as a young woman, June was a very good pianist and rather academic. She recalls June and her friend having such fun together as young women in the 1960's, going shopping, buying beautiful clothes and being very happy. Prior to meeting Peter she had worked in an engineering firm and had been in a relationship with another male.

5. Peter had married in 1964 and had a son with his first wife. Extensive enquiries by Dyfed Powys Police have been unable to locate either Peter's first wife or his son.

6. After a short relationship, June married Peter who was 10 years older than her in January 1970. A year later, they had their first son and two daughters and a second son were born in the following 3 years. June gave up her job as a secretary to care for the children.

7. Peter spent three years on Army Commission abroad before becoming a draughtsman. He left his employment in 1982 on medical grounds.

8. The first record of June and Peter living in West Wales is in 1992. Before this time, it is believed that they resided in Dorset. Between 1992 and 2009, they moved between Carmarthenshire and Pembrokeshire until they rented the cottage sometime in 2009. They remain at the cottage until 2012 when it is believed they moved back to Dorset before returning to rent the cottage in May 2013. They lived in the cottage until June's death in February 2021.

9. The family's decision not to participate in the review has meant that the Panel has had to rely on information provided to the Police as part of the investigation.

Due to the dynamics of relationships within the family, it is unclear whether family members were unwilling to share information or, due to their estrangement did not know how their parents lived their lives and were therefore unable to provide this information.

10. Despite extensive enquiries neither the Panel nor Dyfed Powys Police have been unable, identify any friends or acquaintances of June.

11. The Panel is saddened by its inability to get a sense of June as a person as part of this review. Her invisibility as a person is explored further in the analysis section of the report which also examines how June and Peter lived their lives and their relationship with their family.

SECTION THREE - CHRONOLOGY

1. The chronology below sets out relevant key events, contacts and involvement with June, Peter and their family by agencies, professionals and others who have contributed to the review. It also includes entries made by June in her diary and information gathered in the course of the police investigation.

2. The Terms of Reference set out the scope of the review from May 2013 to the date of June's death in February 2021 but allowed agencies to submit information that fell outside of this scope if deemed relevant and appropriate. This information has been included in the chronology as it provides relevant contextual information that has been considered as part of the review.

3. Direct quotes from documents are included in italics and text messages are included as sent including spelling/grammar.

Date	June	Peter
1980	Health records detail bruised ribs – no explanation recorded	
1981	Health records detail fractured ankle – explanation given as twisted ankle whilst rambling	
1982		Peter leaves employment on medical grounds
1983	Health records detail fractured wrist – explanation given as fell down the stairs	
1985	Health record states fractured ribs – records note cause as a 'blow' but don't detail the cause of the blow	Peter attempts to take his own life
1990	Health record stated that June complained of pain chest and GP questioned fractured ribs. June stated that she had fallen two weeks previously.	
1992 - 2009	During this period of time records of June and Peter registered at addresses in Carmarthenshire and Pembrokeshire. A total of 31 addresses in Health records.	
1993	Health record records head injury – cause given as bumped into lamp post	
1995		A number of letters to the GP practice asking for support in relation to housing issues stating that he couldn't live in cities or near to people
1995		Peter was referred for counselling. In his words, 'the loss of his parents and other past events reinforced his doubts and need for caution, that his military background forced him to ignore nothing and worry about the unknown'. In one report it was noted that he was struggling with issues of power and control. It was noted by the counsellor that it was 'jumbled' and they were trying to 'sort it out' but there is reference to his own powerlessness and perceiving others as having power over him, for example, the DHSS.
1998		Self-reports to the GP that he was having severe panic attacks after a security alarm was activated in his local

		library. He was prescribed Diazepam and anxiolytics that would help reduce anxiety and panic, and an anti-depressant medication.
November 2001		Lengthy consultation with GP where Peter reported that he has had a row with his wife. He feels she is expecting too much of him and him feeling too old to do as much as he could when he was younger. He requested joint counselling for him and June and he was provided with the telephone number for Relate.
March 2002		Attended at GP practice and told them he was at 'the end of his tether' – another row with June. Advised again to contact Relate.
2003	Couple registered with a GP Practice in Carmarthenshire. The registration form asked about marital problems. June did not tick this box but did tick that she was worried about other family members and housing or accommodation problems. Peter's questionnaire when registering with the same practice also did not tick the marital problems box, but did tick depression, worries about other family members, employment change / unemployment, recent retirement and housing or accommodation problems. He also added a note on this registration form that they had moved there on medical grounds.	
2003	Anxiety with depression is referenced in medical records	
2006		Letter provided by GP practice in Dorset to support housing application as a result of stress and insomnia caused by noisy neighbours
2008	Diagnosis of middle ear dysfunction	
15/2/2009		Peter reported an incident to Dorset Police whereby he alleged that he was punched to the right shoulder and hit on his back by a local farmer. The incident had occurred after the farmer dumped manure against a fence abutting Peter's property. Peter went into the field to take some photographs in order to complain and an altercation took place with the farmer. The farmer made

		counter allegations and no charges were brought against either party.
2009	June and Peter rent the cottage in Pembrokeshire and remain there until 2012	
13/6/2012	New patient questionnaire completed at GP practice Pembrokeshire	New patient questionnaire completed at GP practice Pembrokeshire – Peter notes on his questionnaire "*some mental health problems, anxiety etc in 1990s that no longer apply*".
2/7/2012	Dental examination and oral hygiene advice given	Dental examination
1/8/2012		Dental appointment for scale, polish and filling
1/11/12	Patient deregistered in Hywel Dda University Health Board and records sent to relevant Health Authority	Patient deregistered in Hywel Dda University Health Board and records sent to relevant Health Authority
2012 – May 2013	Believed to have returned to Dorset before returning to Pembrokeshire in May 2013	
1/5/2013	June and Peter rent the cottage again from the 1st May 2013 and remain tenants until February 2021	
17/7/2013	Dental appointment – radiograph and fillings	Dental appointment – radiograph and fillings
1/8/2013	Register again at Pembrokeshire GP Practice – patient completes a questionnaire and is offered to attend for a health check	Register again at Pembrokeshire GP Practice – patient completes a questionnaire and is offered to attend for a health check
5/8/2013		Following noted from Peter's questionnaire. Family history of neoplasm. Drinks rarely. Ex pipe smoker
14/9/2013	Dyfed Powys Police record – 85 year old female fallen at the address. Priority changed from IMMEDIATE RESPONSE to PRIORITY RESPONSE. Caller to ambulance is swearing and bring very aggressive to Ambulance. Details of caller unknown. Ambulance are 6 miles away. No need for Police to attend.	
26/9/2013	Breast Test Screening – non-attendance	
16/1/2014	Dental appointment – examination	Dental appointment - examination and radiographs
29/1/2014	Dental appointment – scale and polish	
19/2/2014		GP records note that Peter need blood pressure, flu and pneumococcal vaccinations
25/2/2014		Clinical management plan – advised to make apt for b/p. Influenza vaccine telephone invite. Pneumococcal vaccination declined. Seasonal flu vaccine declined

16/4/2014	Dental appointment – examination and radiographs	
29/4/2014	Dental appointment - fillings	Dental appointment - fillings
7/10/2014	Dental appointment - examination	Dental appointment - examination
11/11/2014	Cervical smear – non attender	
15/4/2015	Dental appointment - examination	Dental appointment - examination
21/10/2015		Dental appointment - examination
23/10/2015	Dental contact – pain – treatment plan agreed as root canal treatment	
28/10/2015	GP Surgery consultation – influenza vaccine declined	Influenza vaccine declined
29/10/2015	Attendance at Emergency Department with swelling to left jaw query an abscess – referred to maxillofacial department Swansea	
29 – 30 /10/2015	2 teeth removed at Hospital and discharged with antibiotics and pain relief	
1/11/2015	Discharge information from Hospital received by GP practice	
24/11/2015	Influenza vaccine declined	
10/12/2015	Dental appointment – examination and radiographs	
29/12/2015		Dental appointment – examination, radiographs and extraction
26/1/2016	Breast screening declined	
1/2/2016	Dental appointment – impression or lower dentures	
11/2/2016	Dental appointment – try in of dentures	
26/2/2016	Lower denture fitted	
8/5/2016	Attended at Hospital with injury to left elbow. Slipped on kitchen floor steps and fell directly onto left elbow. Referred to Trauma and Orthopaedics and went to Ward 1. Noted in medical record the steps were damp. Fall was mechanical in nature. Alcohol not noted to be a feature. Noted she had a drink monthly or less. Then	

	1-2 units only. Note to have never had 6 or more units on a single occasion in the last year. Routine enquiry undertaken and negative response. Not identified as a vulnerable person or at risk of abuse or neglect.	
9/5/2016	Physiotherapy records notes *Patient walking down steps and slipped on damp steps. Fall mechanical in nature. No loss of consciousness, no head injury. X-ray showed fracture left olecranon. Patient neuro-vascularly intact below injury. Consultant plan to elevate in sling for one week, analgesia, clinic review in one week. Notes social history – lives with husband in cottage. Right hand dominant. Independently mobile. Patient lying in supine position, alert and communicating. Patient performed sit to stand independently and mobilised to bathroom and back with minimal supervision. Patient safe with mobility today as right hand dominant. Patient feels able to manage at home. Patient safe for discharge home and to have follow up in outpatients physio and review with Consultant in one week time.*	
24/5/2016	Clinical follow up to the surgery	
21/6/2016	Fracture clinic – wounds redressed and no concerns noted	
21/6/2016	Referral made for Physiotherapy	
22/6/2016	Physiotherapy record notes *Treatment record – out of plaster. Noted social and family history – gardening and cooking. Patient's expectation was for more movement. Assessment of limb recorded – swelling of forearm and hand, wasting biceps, triceps. Noted stiffness and weakness following*	

	the fracture and immobilisation. Tubigrip for swelling, gentle ball squeeze.	
6/7/2016	Physiotherapy appointment – record states *Twinged back this a.m. Using left arm more. Fair grip strengthen. Wall push up, prayer, reverse prayer stretch, elbow extension stretch, scar massage. Review 3 weeks.*	
27/6/2016	Physiotherapy appointment – record states *Can turn tap on now. Still struggling with getting it straight. Wall push up. Contract and relax biceps / triceps. Elbow extension stretch. Discharge with SOS 6 weeks.*	
2/8/2016	Letter from the Physiotherapist to the Trauma and Orthopaedic Surgeon detailing that patient had attended 3 physio appointments after surgery and discharged with a home exercise programme	
30/8/2016	Dental appointment – examination and radiographs	Dental appointment – examination and radiographs
16/9/2016	Administration of for flu vaccination under patient specific direction authorised. Administered by HCA employed by Practice	Patient eligible for flu vaccine
21/10/2016	Dental appointment - fillings	Dental appointment - filling
18/11/2016	Seasonal influenza vaccination declined	Seasonal influenza vaccination declined
19/1/2017		08.44hrs call made to Welsh Ambulance Service by June reporting that Peter had fallen on the steps within the cottage. June stated that she had to come a long way up the drive as they have no mobile phone signal at the cottage and there is no landline at the address. June believed Peter had injured his back and stated she was unable to assist him as had recently fractured her elbow.

		An ambulance attended the address and conveyed Peter to hospital. Attended Emergency Department. Fall after slipping down 3 tiled concrete steps in rented accommodation. Hit elbow and right flank. Notes state slipped backwards and fell down the stairs. Brought in as elevation on ECG. No drug history, non-smoker, no alcohol. ECG No Abnormality Detected. Bruise over elbow and laceration noted. Musculoskeletal injuries only. Did note is on housing benefit, inadequate heating in house. Advised to speak to council re adequacy of heating and to take flu jab. Discharged.
19/1/2017		Report sent from Emergency Department to GP Practice
24/4/2017	Dental appointment – examination and complaining of painful gums	Dental appointment - examination
2/6/2017	GP record states *Surgery consultation Discussion: wanted to ensure letter from A&E had come to surgery: explained that received. Reports that wire palpable on left elbow. Not concerned, occasionally knocks. No change since surgery. Explained sometimes 'pushed out' by body. Options discussed- wishes to watch and wait but will report if bothersome for T&O referral. Discussion about disorder. Options discussed – requests olive oil and syringe. Will make appointment. On examination wax in ear. Bilateral- compacted, hard. Hearing difficulty. Bilateral cracking and slight fullness. Feels like previous wax. No red flags, no pain or discharge.*	
15/6/2017	Syringe ear to remove wax	

14/9/2017	Authorised flu vaccine	Patient eligible for flu vaccine
		Text message sent from Peter's phone to Daughter 2 at 13.18hrs *Mum is upset. Son 1 made nuisance call before we got your letter. How dare you do this. Had legal advice. New numbers soon. Mum is frightened of him. She wants minimal contact with you. I am nearly 80. Leave us alone. Mum fears medical effect on us at our age. Eleven years ago he sinned by wishing mum to die. No priest tolerates that sin. Dad. Do not reply.*
24/10/2017	Dental appointment - examination	
2/11/2017	Direction for pneumococcal vaccination to be administered	Direction for pneumococcal vaccination to be administered
20/11/2017	Dental appointment – scale and polish	
22/2/2018	GP clinic – dental abscess right upper canine. Reports that can't see dentist until tomorrow, prescribed antibiotics.	
23/2/2018	Dental appointment - Assessment and advice. Radiographs. Patient complains of past pain and swelling on UR5. Went to the GP where she was given a 5-day course of Amoxicillin (500 mg every 8h)	
26/2/2018	June contacts GP requesting second course of antibiotics. Due to see dentist on Friday but worried that they will fail to keep appointment due to bad weather. Noted in GP records that poor mobile signal.	
28/2/2018	Dental appointment - extraction	
3/3/2018		Dyfed Powys Police Call from Peter reporting person or persons unknown had dumped a load of snow in front of his access. Caller initially very irate on phone and everyone in Wales was incompetent. Caller stated he was ex-army

		and had gone into survival mode. Caller concerned that should he or his wife need assistance they could not get out nor emergency vehicles in. Safeguarding advice provided – Caller relatively calm at end of call.
23/5/2018	Dental appointment - examination	Dental appointment - examination
7/6/2018	Dental appointment – filling, scale and polish	
15/10/2018		Text message sent from Peter's phone to Daughter 2 at 12.48hrs *Disappointed. Application collapsed and lost fee. Costly flat hidden obligations. Huge deposit req bad insulation. Hb would be 4 wks in areas. Realk tried xx*
28/10/2018		Text message sent from Peter's phone to Daughter 2 at 13.49hrs *Both ok need rest after move attempt. benft rules notnot allow to ever assist. Accept we must where we decide suitable. Good luck nu job xxx*
17/12/2018		Text message from Peter's phone to Daughter 2 14.32hrs *Read yr txts. Son 2 premier is good. Xmas card in post to yu. Xx mum dad* *14.38hrs* *Son 2 hotel ok dad* *14.57hrs* *Xmas card etc posted today xx dad mum*
17/12/2018		Text message from Peter's phone to Daughter 1 at 14.52 *Hope ur well.Parcel came in post. Card to u funmi lanre posted today. Xx mum dad*

19/12/2018		Text message from Peter's phone to Daughter 2 at 10.25hrs *Short daytime now. I never drive here at night. Ask Son 2 to arrive by eleven am.*
28/12/2018		Text message from Peter's phone to Daughter 2 at 15.20hrs *You sent two texts on 16th dec both saying son 2 would see us in hwest on 31 dec ie Monday xx dad*
7/1/2019	Dental appointment – examination and radiographs	Dental appointment – examination and radiographs
22/1/2019		Dental appointment - filling
27/1/2019		Attends at Emergency Department with a swollen face. Medical records state *Early cellulitis ? insect bite. Assessment of acute condition, noted swelling to right side of face the previous night. No toothache but feels strange. Recently seen by dentist, filling left side of mouth. Slight swelling to lower jaw. Impression cellulitis. Treated antibiotics and discharged.*
27/1/2019		Report from Hospital sent to GP
7/3/2019	Mammogram not attended Breast Screening Wales	
17/6/2019		Text message from Peter's phone to Daughter 2 13.45hrs *Hi I was starting my txt to u and yours pinged thankr for card only card I got it came sat love xx dad mtm* *June birthday 6th June
15/7/2019		Text message from Peter's phone to Daughter 2 19.25hrs *Hi new address not not written on dday card. We both looked inside envelope. Was nijj else. Dad mum* xx

20/7/2019		Text message sent from Peter's phone to daughter 2 at 12.03hrs Hi. U are busy and we hav dental staff chaos. U may prefer seing nxt year. Explain nxt text. Dad 12.14hrs Ten days ago ltr said our dentist gone. Poor service all yr. Future delays certain. Third txt nxt. 12.36hrs We transferd to nothr branch last wed vry far awy. We must accept short nortce pointments. Many needed. V bad teeth as we r old. Dad mum xx 12.59hrs U may delay visit till next year. We can not predict dates at dentist we must urgent help at short notice eg cancellations. Dad
22/7/19		Text message from Peter's phone to Daughter 1 13.45hrs Hi dental chaos do not plan train. Ltr told us our dman gone. We trnsfrd to branch v far away. Nxt txt follows dad 13.54 We can not predict evts. Must accept short ntice dats or cancltions. We hve poor teth. Sory. U come nxt yr prhps. Xx dad mum to all
12/8/2019	Dental appointment – examination, radiographs and fillings	Dental appointment – fillings and extraction
2/9/2019	Recall for seasonal flu vaccination	Recall for seasonal flu vaccination

13/9/2019	Authorisation to give flu vaccination	
19/9/2019	Invitation for flu vaccine sent via text message	Invitation for flu vaccine sent via text message
8/10/2019		Invitation for flu vaccine sent via text message
14/10/2019	Recall for shingles vaccination	Recall for shingles vaccination
22/11/2019	Invitation for flu vaccine sent via text message	Invitation for flu vaccine sent via text message
19/2/2020	Dental appointment – standard recall for examination. June reported that she couldn't get used to the denture. Option of having another made – would like to think about it	Dental appointment - examination
24/2/2020	Seasonal influenza vaccination declines not responded to x3 text messages	
3/3/2020		3rd SMS text message sent for influenza vaccine
3		
10/3/2020	No response to bowel cancer screening programme invitation. This is a screening message – NO ACTION REQUIRED	
18/3/2020		Incoming call from daughter 1 to Peter's mobile at 10.44hrs – lasted 19minutes 52 seconds Text exchange between Peter's phone and Daughter2 relating to shopping channel (4 texts in total between 11.30hrs and 12.45hrs)
24/3/2020		Text from Peter's phone to Daughter 2 at 14.44hrs *Hi. Card came in post. Dad xxxxx* *Mother's Day was 22nd March 2020
23rd March 2020	National Lockdown in response to Covid 19 Pandemic – 'Stay at Home' requirement and closure of all non-essential retail and hospitality	
5/4/2020		Attended Emergency Department tent (tent outside ED to assess patients and treat where appropriate to avoid admission due to Covid – 19 risks) Complained of sore mouth. Saw dentist 8 months ago – extraction 2 months ago – nil done. c/o diffuse pain: lower jaw incisors and

		right side. Taken Paracetamol x 2 doses daily. Past medical history nil significant. Drug history – nil. On exam – nil obvious see apart from very caries teeth. 1 very small rubbery tender lymph nose right anterior cervical region. Advised patient I am not a dentist; not qualified to treat dental issues; would not normally treat this but due to current crisis I will. Advised him to contact his own dentist first thing in the morning. For Amoxycillin 500mgs tds for 7 days
6/4/2020		Contacted dentist – clinical advice given
8/5/2020	Covid restrictions in Wales extended for a further 3 weeks	
29/5/2020	'Stay at Home' message changed to 'Stay Local' in Wales. Two households can meet outdoors with social distancing.	
22/6/2020	Non-essential retail reopens. Sta Local message continues in Wales.	
6//7/2020	Stay Local message in Wales is lifted	
6/7/2020	Pneumococcal vaccination invitation SMS text message sent	Pneumococcal vaccination invitation SMS text message sent
23/7/2020	Administration of shingles vaccine	
3/8/2020	Further lifting of Covid restrictions in Wales	
22/8/2020	Further lifting of lockdown restrictions in Wales	
24/9/2020	Authorisation for seasonal flu vaccination	Authorisation for seasonal flu vaccination
6/10/2020	Invitation for flu vaccine sent via text message	Invitation for flu vaccine sent via text message
13/10/2020	Authorisation for pneumococcal vaccination	
23/10 – 9/11 2020	Circuit Breaker introduced in Wales in response to increase in Covid cases. Stay at Home message introduced and hospitality and non-essential retail closed.	
23/10/2020		FGP records a failed encounter – message left on answer machine. Tried to ring to offer flu vaccine. Text message sent out. Please contact GP Surgery
27/10/2020	GP practice received letter from patients. *Please delete 07415602038 from your records as this phone is no longer in use. This property is rented and has no BT phone line. It is in a POOR RECEPTION mobile phone area. So any use of a mobile can only be some distance away from us. It is not the best of situations but being on Benefits it is all we can presently afford.*	

	Should it be essential to contact us perhaps writing a letter is the only option. Many thanks Signed by both Peter and June	
30/10/2020	SMS text message sent to patient	SMS text message sent to patient
3/11/2020	Declined consent for short message service texting	Declined consent for short message service texting
5/11/2020		Text message sent from Peter's phone to daughter 2 at 14.45hrs *Mum dad very well. Essential shops always open. Car good Love to all xxx*
20/11/2020		Text message to Peter's phone from Daughter 2 at 14.54hrs *Hi dad/mum. How you both doing? I hope you are keeping well. Would be nice to chat to you so let me know when's good over the weekend. Love xx*
19/12/2020	Level 4 Covid Restrictions re-introduced in Wales including 'Stay at Home' and closure of all non-essential retail/hospitality. These restrictions were still in place at the time of deaths in February 2021.	
24/12/2020	Text message to June's phone from Daughter 2 at 11.13hrs *A huge thank you for your beautiful Christmas card and money. The girls eyes lit up, it was very kind of you both. How are you keeping? With this virus and rainy weather its been miserable. I hope you are both well. I had planned to send you a lovely package but with main shops opening/closing I've not been that organised. I'm sorry but you will have something belated. I've even warned the girls that gifts are a bot light this year……All is good and we are keeping well so that's the important thing. I've tried calling you today. It would be wonderful chatting to you both tomorrow, maybe indicate what time might be best as I know your reception isn't that great. Miss you both around this time of year. Love xxx*	Text message to Peter's phone from Daughter 2 at 11.13hrs *Morning mum and dad. I must apologise. I have changed my phone provider and may have sent text to an old number stored in my contacts.* *A huge thank you for your beautiful Christmas card and money. The girls eyes lit up, it was very kind of you both. How are you keeping? With this virus and rainy weather its been miserable. I hope you are both well. I had planned to send you a lovely package but with main shops opening/closing I've not been that organised. I'm sorry but you will have something belated. I've even warned the girls that gifts are a bot light this year……All is good and we are keeping well so that's the important thing. I've tried calling you today.*

		It would be wonderful chatting to you both tomorrow, maybe indicate what time might be best as I know your reception isn't that great. Miss you both around this time of year. Love xxx Response from Peter's phone to daughter 2 at 13.03hrs *Endless xcuses. Golden wedin anv ignored by everyone. One card brother this xmas. Mum pissed off. Letters only now on.*
25/12/2020 12.21hrs	Text message to June's phone from Daughter 1 *Merry Christmas M+D. Wish you a nice day. I sent card and voucher, know there are postal delays so if not arrived I hope it will soon, Love xxx*	
25/12/2020 20.27hrs	Text message to June's phone from Daughter 2 *Merry Christmas mum and dad. We have tried calling you today. Hope you had a lovely day, best wishes xx*	Text message to Peter's phone from Daughter 2 *Merry Christmas mum and dad. We have tried calling you today. Hope you had a lovely day, best wishes xx*
26/12/2020		Daughter 2 sends a video message to Peter's phone
5/1/2021	Records in diary *Had a fall*	
11/1/2021	Records in diary *Pain is now unbearable*	
12/1/2021	Records in diary *What is there to live for in this horrible sad lonely world*	
13/1/2021	Records in diary *What is there to live for in this horrible sad lonely world*	
14/1/2021	Records in diary *Time to go*	
15/1/2021	Records in diary *Too much pain*	Authorisation for COVID 19 vaccination
16/1/2021	Records in diary *Want to die soon*	

17/1/2021	Records in diary *Last beautiful journey round Gwaun valley*	
19/1/2021	Records in diary *Too much pain*	Text message to Peter's phone from Daughter 2 *Hi Dad. Tried calling a few times. Hope you and mum are keeping fit and well. All fine with us. Love xxx*
20/1/2021	Records in diary *Let me die*	
21/1/2021		Text from Peter's phone to Daughter 2 *Tbx for text both well. My fone says it cannot accept your dvd. Ours is old two g gsm. Love mum to all xxx*
26/1/2021	Record in diary *Anniversary*	Failed encounter x2. No answer when tried to contact re COVID vaccine.
26/1/2021		Missed call from Health Centre – no message left.
29/1/2021	Record in diary *Son 1*	Failed encounter No answer when tried to contact re COVID vaccine. Message left on answer phone.
2/2/2021	Authorisation for COVID 19 vaccination	
3/2/2021	Covid vaccine – refusal to start or complete the course	Covid vaccine – refusal to start or complete the course
4/2/2021		6 calls made from Peter's mobile to Pembrokeshire County Council Waste Team 09.46hrs Answered and lasts 1 minute 12 seconds 09.54 hrs Not answered 09.55hrs Answered and lasts 1 minute 26 seconds *this was an incoming call 12.42hrs Not answered 12.44hrs Answered and lasts 2 minutes 11 seconds 13.21hrs Answered and lasts 1 minute 37 seconds
7/2/2021		Text message to Peter's phone at 15.07hrs from the Property Surveyor asking Peter to let him know available dates for the survey to be conducted.
8/2/2021	Records in diary *I am not well*	

8/2/2021		Text message to Peter's phone at 09.40hrs from the Property Manager asking for Peter to call him to arrange for an assessor to carry out the energy performance certificate
8/2/2021		Outgoing call from Peter's phone to Dentist at 9.46hrs. lasting 10 minutes and 9 seconds. Text message received at 10.07hrs confirming appointment with Dentist on 31st March 2021. Three further calls made to the Dentist at 10.25hrs, 10,26hrs and 10.31 hrs. The call at 10.31hrs was answered and lasted 2 minutes and 22 seconds.
8/2/2021	Vehicle belonging to Peter and June travelling towards Haverfordwest and returning (ANPR camera)	
8/2/2021 12.01hrs	Incoming call to June's mobile from Peter – from time of the call this was when they were out (from the timings of the ANPR sightings above)	
8/2/2021		12.26hrs Peter's mobile phone is topped up with credit to the total of £13.97
8/2/2021		15.40hrs Phone call from Peter's phone to Anchor Care Homes – call lasted 15 minutes and 43 seconds 15.57hrs phone call from Peter's mobile to Wales and West Housing Association which lasted 5 minutes and 3 seconds 16.02hrs Call from Peter's mobile to Belvoir Real Estate Agency in Bournemouth lasting 21 seconds
8/2/2021		19.29hrs call from Peter's mobile to Property Manager lasting 2 minutes and 29 seconds. Peter leaves a voicemail for the Property Manager stating that he could not have anyone attend the property as he has a

		medical emergency as he had found a 'lump on his right tit'. He further stated that he would likely need to move from the property into nursing care accommodation and he absolutely couldn't have anyone attend at the property for at least the next few weeks.
9/2/2021	Records in diary *Cannot cope much longer – health/housing.* *Peter has cancer*	09.58hrs phone call made from Peter's mobile to the Property Manager lasting 1 minute and 48 seconds 10.00hrs and 10.09hrs calls made from Peter's mobile to Pembrokeshire County Council Waste Team 13.27hrs Phone call to Peter's mobile from the GP Practice – no message left
10/2/2021	Records in diary *Cannot cope much longer – health/housing.* *Peter has cancer*	Phone call from Peter's mobile to the Property Manager at 12.09hrs (4 minutes and 39 seconds) The property manager recalls that Peter said that he may have jumped the gun a little as he hadn't seen a doctor regarding the lump and if they needed an assessor to come to the property then they can do so. Monday 15th February was provisionally agreed and the Property manager agreed to confirm via a text message once spoken to the assessor. Peter asked what would happen if lots of work needed at the property to which the Property manager said to wait to see what the assessor said. Peter stated that they would likely want to leave the property before next winter as they were both getting older and want to be closer to family back in England. The Property manager explained that they would need to give a month's notice in writing. Peter thanked him for everything he had done over the years

		and said he considered him a good friend and ended the call abruptly.
11/2/2021	Records in diary *Really is the end*	
11/2/2021	Vehicle belonging to Peter and June travels towards Haverfordwest at 10.40 and returning 12.05 (ANPR camera). CCTV in Aldi supermarket show the couple shopping in store between 11.40 and 11.52hrs.	
12/2/2021	Records in diary *I want Peter to end my life*	Phone call from Peter's mobile to the Property Manager at 14.37hrs (1 minute 21 seconds)
12/2/2021	Vehicle belonging to Peter and June travelling on the A40 between Fishguard and Goodwick and returning.	
13/2/2021	June and Peter go to the Post Office in Fishguard – CCTV shows them entering the Post Office at 10.18hrs and leaving at 10.23hrs. They also attend the CK supermarket in Fishguard where they are seen on CCTV.	
13/2/2021	Records in diary *I want Peter to end my life*	
15/2/2021	Records in diary *I am ill*	
15/2/2021	Property surveyor attends at June and Peter's cottage at 10.15hrs. Peter has left a note outside the property and requests that the Surveyor reads this before entering. The note stated that both Peter and his wife are shielding and provides in depth notes about the survey and a detailed floorplan of the property. The surveyor states that he had a technical discussion with Peter in relation to the house. He notes that June remained in the bedroom throughout the survey. When he entered the bedroom she smiled and said hello. Peter commented on the disrepair of the house and that he wouldn't be spending another winter there – that it was damp and the cold not good for their health. He further stated that mobile reception as poor, that there was no landline and that he wasn't going to incur the costs of a landline. The surveyor leaves the property at 10.32hrs.	
16/2/2021	Records in diary *Peter has cancer*	
17/2/2021	Records in diary *The End*	

SECTION FOUR - OVERVIEW AND ANALYSIS

1. This section provides an overview and analysis of information and examines the key lines of enquiry included in the Terms of Reference for the review as well as concluding remarks.

2. How June Lived her Life

2.1 In light of the family's decision not to participate in the review our information relating to June and how she lived her life is provided only by statements to the police, agency IMRs and accounts from individuals that the Chair has spoken to as part of the review.

2.2 June's sister recalls that as a young woman June was a very good pianist and rather academic. She remembers June and her friend having such fun together as young women, going shopping, buying beautiful clothes and being very happy. June worked in an engineering firm and as a secretary before meeting Peter.

2.3 After a short relationship, June married Peter who was 10 years older than her in January 1970. A year later, they had their first son and two daughters and a second son were born in the following 3 years. June gave up her job as a secretary to care for the children.

2.4 These recollections by June's sister included in the antecedent statement for the Coroner's Inquest are the only family insight we really have into June as a person, and this is before her marriage to Peter in 1970. June's sister does not provide any account of her sister after her marriage to Peter. It was noted by the Panel that June, as an individual and the character that her sister describes prior to her marriage becomes invisible even to those closest to her.

2.5 The Panel note that it appears to have been a whirlwind relationship before June and Peter marry. Whilst this was 50 years ago this commitment 'whirlwind' is identified by Professor Jane Monckton Smith as a stage of the Homicide Timeline; relationships developing very quickly with the aim of being able to secure a commitment.[15]

2.6 There is a reoccurring theme in statements by family members and the landlord of the property that, as a couple, June and Peter they kept themselves to themselves.

2.7 Daughter 2 describes her parents as *private people who kept themselves to themselves and would not appreciate others knowing their business* and June's sister stated that they *didn't want contact with anyone.*

2.8 The landlord of the cottage described them as keeping themselves to themselves and he hadn't had contact with them in person for a number of years despite being their closest neighbour. As his parent property was in sight of the cottage

[15] In Control; Dangerous Relationships and How They End in Murder; Jane Monckton Smith; Bloomsbury 2021

he was able to tell the Chair that he wasn't aware of any visitors to the cottage in the time that June and Peter had been tenants there.

2.9 Despite the extensive enquiries made by Dyfed Powys Police as part of the investigation, they were unable to identify any friends or acquaintances of June nor Peter and no evidence of them being part of any activities in the community.

2.10 The landlord was able to tell the Chair that June and Peter went out most Tuesday and Saturday mornings and that they were always together. From his property, he would see their car being driven up the track towards the main road. Peter was always driving. The routine of June and Peter leaving the cottage on Tuesdays and Saturdays tie in with the ANPR and CCTV footage obtained as part of the investigation, which indicates that the couple would go to Haverfordwest on a Tuesday and Fishguard on a Saturday to do their shopping, and banking at the Post Office.

2.11 There is reference in June's medical notes to a number of injuries to her toes/foot that she had sustained when out rambling. This is also referenced in one of the GP Practice registration forms as an activity she enjoys. The landlord also recalls seeing June and Peter heading out walking when they first moved to the cottage but not in recent years.

2.12 In the CCTV footage of June in the week before her death she is using a walking stick whilst shopping.

2.13 In 2016, during one of her appointments with the Physiotherapist it is noted that June enjoys gardening and cooking.

2.14 Having read June's sister's account of her ability as a pianist when she was younger, it was ascertained that there was an old Hi-Fi at the property and a number of CDs, which may indicate that June continued to enjoy listening to music.

2.15 There was nothing 'personal' on display at the cottage. The only photos found were in a box underneath June's bed that contained photos of family members.

2.16 The landlord recalls an incident when an ambulance had come to the property one morning and he had gone to the cottage to see if everything was ok. Peter had slipped and fallen in the cottage and June was anxious that she might have to drive. He recalls her saying that she hadn't driven for a number of years and had no confidence. This was the only occasion he had spoken to June in the time they had been tenants at the cottage and he described her as *a quiet person*.

2.17 When speaking with the Chair, the Landlord described visiting the cottage after June's death and *was struck by the amount of food there*. He used the word *hoarding* to describe the amount of food in the kitchen and also the fresh groceries in the fridge and the outhouse. He describes the cottage as being tidy inside, furnished but very cold and it felt damp, with black mould growing on the

walls. He wasn't sure how much the heating was being used and was aware of the fire being used only occasionally as he could see smoke from the chimney.

2.18 The couple had one joint bank account. All pensions and benefits were paid into this account and having checked with the Department of Work and Pensions June and Peter were both in receipt of the full benefits that they were entitled to receive.

2.19 The last cash withdrawal was made from the account on the 1st February 2021 for £500 cash. This is a monthly pattern of withdrawals with the exception of December 2020 when £1000 cash was withdrawn. When linked with text messages to Daughter 2 in December 2020 this increase in the amount of cash withdrawn is likely to equate to Christmas and monetary gifts sent to grandchildren. Rental for the property was paid monthly via direct debit. The pattern of monthly cash withdrawals support what Peter writes in one of the letters found in the property;
My wife and I only use CASH for all payments and purchases. We rarely if ever use debit card and do not have a credit card. We are both unhappy using electronic payment – happiest with cash.

2.20 There was several thousand pounds in the bank account at the time of June's death and a large quantity of cash found in the cottage when searched by the Police.

2.21 There were two mobile phones in use at the time of June's death. Mobile phone records indicate that one was used by June and the other by Peter. Records indicate that the one used by June was only used for incoming texts. The last text received was from Peter on the 8th February 2021 when it is likely that they were both in Haverfordwest and may indicate that they had separated and the text was the means of communication to meet up.

2.22 The only contacts saved on June's phone are those of Daughter 1 and Daughter 2, Daughter 2's husband, Peter, Dentist, the property management company, the Doctor, Haverfordwest library and the landlord.

2.23 The second phone is that used by Peter. Contacts on the phone include Daughters 1 and 2, June, Brother, Doctor, Dentists (5 practices listed) and general numbers e.g. garages and the property management company. The records for this phone show texts/calls back to 2017 and it is evident that this is the main phone used up to the time of June's death. From examining the phone records, it is clear that it is Peter who uses this phone, effectively controlling the communications with the outside world and Daughters 1 and 2.

2.24 It is the number for this phone that the GP practice is asked to delete from their records even though it is still being used regularly by Peter up to the time of June's death.

2.25 It appears that June and Peter led very isolated lives, both from their families and society. Their children had never visited the cottage in the time they had

been tenants and it does not appear that they had any visitors during the eight years of their tenancy.

2.26 In one of the letters found in the cottage Peter writes *I have NEVER been on holiday abroad. We did intend a foreign holiday but COVID kept going on and on.*

2.27 As a couple, they were fundamentally self-sufficient, not relying on anyone else and declining offers of help from a neighbour during the national lockdowns. It is the Panel's view however that this self-sufficiency was used by Peter as a means of control and the creation of extreme dependency on him by June. It is Peter who does all of the engagement with the outside world; letters, phone calls, interaction at the Post Office, supermarkets and with agencies.

2.28 Throughout the review, the Panel have been presented with information that reflects a narrative from Peter's perspective and we are saddened how invisible to others June appears to have become as a person in her own right.

2.29 June's diary entries in the month leading to her death suggest a sense of desperation and sadness. The diary entries are shown below alongside the activity in the Chronology:

5/1/2021	Records in diary *Had a fall*	
11/1/2021	Records in diary *Pain is now unbearable*	
12/1/2021	Records in diary *What is there to live for in this horrible sad lonely world*	
13/1/2021	Records in diary *What is there to live for in this horrible sad lonely world*	
14/1/2021	Records in diary *Time to go*	
15/1/2021	Records in diary *Too much pain*	Authorisation for COVID 19 vaccination
16/1/2021	Records in diary *Want to die soon*	
17/1/2021	Records in diary *Last beautiful journey round Gwaun valley*	
19/1/2021	Records in diary *Too much pain*	Text message to Peter's phone from Daughter 2 *Hi Dad. Tried calling a few times. Hope you and mum are keeping fit and well. All fine with us. Love xxx*
20/1/2021	Records in diary *Let me die*	

21/1/2021		Text from Peter's phone to Daughter 2 *Tbx for text both well. My fone says it cannot accept your dvd. Ours is old two g gsm. Love mum to all xxx*
26/1/2021	Record in diary *Anniversary*	Failed encounter x2. No answer when tried to contact re COVID vaccine.
26/1/2021		Missed call from Health Centre – no message left.
29/1/2021	Record in diary *Son 1*	Failed encounter No answer when tried to contact re COVID vaccine. Message left on answer phone.
2/2/2021	Authorisation for COVID 19 vaccination	
3/2/2021	Covid vaccine – refusal to start or complete the course	Covid vaccine – refusal to start or complete the course
4/2/2021		6 calls made from Peter's mobile to Pembrokeshire County Council Waste Team 09.46hrs Answered and lasts 1 minute 12 seconds 09.54 hrs Not answered 09.55hrs Answered and lasts 1 minute 26 seconds *this was an incoming call 12.42hrs Not answered 12.44hrs Answered and lasts 2 minutes 11 seconds 13.21hrs Answered and lasts 1 minute 37 seconds
7/2/2021		Text message to Peter's phone at 15.07hrs from the Property Surveyor asking Peter to let him know available dates for the survey to be conducted.
8/2/2021	Records in diary *I am not well*	
8/2/2021		Text message to Peter's phone at 09.40hrs from the Property Manager asking for Peter to call him to arrange for an assessor to carry out the energy performance certificate
8/2/2021		Outgoing call from Peter's phone to Dentist at 9.46hrs. lasting 10 minutes and 9 seconds.

		Text message received at 10.07hrs confirming appointment with Dentist on 31st March 2021. Three further calls made to the Dentist at 10.25hrs, 10,26hrs and 10.31 hrs. The call at 10.31hrs was answered and lasted 2 minutes and 22 seconds.
8/2/2021	Vehicle belonging to Peter and June travelling towards Haverfordwest and returning (ANPR camera)	
8/2/2021 12.01hrs	Incoming call to June's mobile from Peter – from time of the call this was when they were out (from the timings of the ANPR sightings above)	
8/2/2021		12.26hrs Peter's mobile phone is topped up with credit to the total of £13.97
8/2/2021		15.40hrs Phone call from Peter's phone to Anchor Care Homes – call lasted 15 minutes and 43 seconds 15.57hrs phone call from Peter's mobile to Wales and West Housing Association which lasted 5 minutes and 3 seconds 16.02hrs Call from Peter's mobile to Belvoir Real Estate Agency in Bournemouth lasting 21 seconds
8/2/2021		19.29hrs call from Peter's mobile to Property Manager lasting 2 minutes and 29 seconds. Peter leaves a voicemail for the Property Manager stating that he could not have anyone attend the property as he has a medical emergency as he had found a 'lump on his right tit'. He further stated that he would likely need to move from the property into nursing care accommodation and he absolutely couldn't have anyone attend at the property for at least the next few weeks.
9/2/2021	Records in diary *Cannot cope much longer – health/housing.*	09.58hrs phone call made from Peter's mobile to the Property

	Peter has cancer	Manager lasting 1 minute and 48 seconds 10.00hrs and 10.09hrs calls made from Peter's mobile to Pembrokeshire County Council Waste Team 13.27hrs Phone call to Peter's mobile from the GP Practice – no message left
10/2/2021	Records in diary *Cannot cope much longer – health/housing.* *Peter has cancer*	Phone call from Peter's mobile to the Property Manager at 12.09hrs (4 minutes and 39 seconds) The property manager recalls that Peter said that he may have jumped the gun a little as he hadn't seen a doctor regarding the lump and if they needed an assessor to come to the property then they can do so. Monday 15th February was provisionally agreed and the Property manager agreed to confirm via a text message once spoken to the assessor. Peter asked what would happen if lots of work needed at the property to which the Property manager said to wait to see what the assessor said. Peter stated that they would likely want to leave the property before next winter as they were both getting older and want to be closer to family back in England. The Property manager explained that they would need to give a month's notice in writing. Peter thanked him for everything he had done over the years and said he considered him a good friend and ended the call abruptly.
11/2/2021	Records in diary *Really is the end*	
11/2/2021	Vehicle belonging to Peter and June travels towards Haverfordwest at 10.40 and returning 12.05 (ANPR camera). CCTV in Aldi supermarket show the couple shopping in store between 11.40 and 11.52hrs.	

12/2/2021	Records in diary *I want Peter to end my life*	Phone call from Peter's mobile to the Property Manager at 14.37hrs (1 minute 21 seconds)
12/2/2021	Vehicle belonging to Peter and June travelling on the A40 between Fishguard and Goodwick and returning.	
13/2/2021	June and Peter go to the Post Office in Fishguard – CCTV shows them entering the Post Office at 10.18hrs and leaving at 10.23hrs. They also attend the CK supermarket in Fishguard where they are seen on CCTV.	
13/2/2021	Records in diary *I want Peter to end my life*	
15/2/2021	Records in diary *I am ill*	
15/2/2021	Property surveyor attends at June and Peter's cottage at 10.15hrs. Peter has left a note outside the property and requests that the Surveyor reads this before entering. The note stated that both Peter and his wife are shielding and provides in depth notes about the survey and a detailed floorplan of the property. The surveyor states that he had a technical discussion with Peter in relation to the house. He notes that June remained in the bedroom throughout the survey. When he entered the bedroom she smiled and said hello. Peter commented on the disrepair of the house and that he wouldn't be spending another winter there – that it was damp and the cold not good for their health. He further stated that mobile reception as poor, that there was no landline and that he wasn't going to incur the costs of a landline. The surveyor leaves the property at 10.32hrs.	
16/2/2021	Records in diary *Peter has cancer*	
17/2/2021	Records in diary *The End*	

2.30 It is not known whether Peter had access to, or knew the content of June's diary. When read in isolation, June's diary entries portray physical pain, loneliness, desperation and finality. At the same time that the entries are being made June and Peter are continuing with their weekly routine of shopping in Haverfordwest and Fishguard and Peter is making arrangements for appointments at the Dentist and in communication with the Property Manager in relation to the survey; the normality of which seem in contrast to how June is portraying how she feels in her diary.

2.31 The Panel has questioned the reality that Peter may have been creating for June especially in relation to her belief that Peter has cancer. Whilst it is reported that he has found a lump on his chest he has not made any attempts to seek medical advice. It is also noted by the Panel that an examination of this lump during the post-mortem concluded that this was likely to be a cyst and nothing more sinister

2.32 The Panel has been unable to get a real sense of June as a person and how she lived her life day to day.

3. Relationships with Family Members

Our relationship with parents quite estranged – my parents didn't have regular contact with us. There were no fallouts or ill feeling just not a close relationship, but I do know that our parents loved us and their grandchildren

3.1 The above was how Daughter 2 described her and her sibling's relationship with their parents in the antecedent statement for the Coroner.

3.2 When contacted by Dyfed Powys Police as part of the investigation into the death of June the 4 children were able to contribute very little to an understanding of their parents' lives. None had visited their parents in the cottage, and they were unable to confirm where their parents had lived prior to moving there.

3.3 As part of the police investigation the Family Liaison Officer contacted June and Peter's four adult children. The Liaison Officer spoke to Son 1, Daughter 2 and Son 2 and also to June's sister and Peter's brother. June's sister stated that she had last had contact with her sister 10 years ago and Peter's brother recalled having contact with his brother once in the last ten years.

3.4 On hearing about the DHR, the Family Liaison Officer describes the relationship with the family as changing, becoming more guarded and unwilling to share information. The statements from the adult children included in this section are those made to the Family Liaison Officer prior to family members becoming aware of the DHR unless otherwise stated.

3.5 Son 1 and Daughter 2 recall a 'hard upbringing'.

3.6 June's sister told Dyfed Powys Police that both sons came to live with her when Peter made them leave home at 16 years of age.

3.7 In terms of relationships and contact between June and her adult children, Dyfed Powys Police were told that there had been no contact with Son 1 since 2007. In phone, records dated 2017 Peter states in a text message to Daughter 2 that Son 1 had made a nuisance call to them. The text message read:

Mum is upset. Son 1 made nuisance call before we got letter. How dare you do this. Had legal advice. New numbers soon. Mum is frightened of him. She wants minimal contact with you. I am nearly 80. Leave us alone. Mum fears medical effect on us at our age. Eleven years ago he sinned by wishing mum to die. No priest tolerates that sin. Dad. Do not reply

3.8 This is the only reference to Son 1 in any communication. June does however note Son 1's birthday in her 2021 diary.

3.9 Son 1 spoke to the Dyfed Powys Family Liaison Officer and described his father as a 'monster'. He recalled an incident when he was between the ages of 12-16 when his father poured petrol on himself and threatened to set himself on fire.

3.10 In 2018, Son 1 made an allegation of non-recent physical and emotional abuse against his father. This report was made to the Metropolitan Police however when officers contacted Son 1 he didn't feel able to pursue this complaint. At the time of finding out about June's death her sister said to Dyfed Powys Police that Son 1 *had issues that he would hopefully be free of now.*

3.11 As family members chose not to participate in the DHR the Panel were unable to ascertain what had happened between Son 1 and his parents to lead to the breakdown that was evident in their relationship. Based on the limited information known to the Panel regarding Son 1's relationship with his parents it is their view that Son 1 had experiences in his childhood which have impacted on his health and well-being as an adult and he holds Peter, and June to an extent responsible for this.

3.12 Phone records indicate that Son 2 may have visited Pembrokeshire in December 2018 but there is no evidence of direct phone contact with him in any of the phone records seen by the Chair.

3.13 Daughter 2 maintains the most contact with June and Peter as is evidenced in the chronology, but it appears that it is Peter who responds to all text messages, controlling the communication with their adult children despite messages being sent to June's phone from daughters 1 and 2.

3.14 His message to Daughter 2 in October 2017 suggests that he is angry at her and asks her not to reply.
Mum is upset. Son 1 made nuisance call before we got letter. How dare you do this. Had legal advice. New numbers soon. Mum is frightened of him. She wants minimal contact with you. I am nearly 80. Leave us alone. Mum fears medical effect on us at our age. Eleven years ago he sinned by wishing mum to die. No priest tolerates that sin. Dad. Do not reply.

3.15 In July 2019, there are a number of text exchanges between Peter and his two daughters. It appears that the daughters are planning to visit but Peter tells them not to and suggests they come next year. The reason he gives is *dental chaos* and he explains that their dentist has left the practice and they have had to register with another practice.
Texts to Daughter 2

Hi. U are busy and we hav dental staff chaos. U may prefer seing nxt year. Explain nxt text. Dad
Ten days ago ltr said our dentist gone. Poor service all yr. Future delays certain. Third txt nxt.
We transferd to nothr branch last wed vry far awy. We must accept short nortce pointments. Many needed. V bad teeth as we r old. Dad mum xx
U may delay visit till next year. We can not predict dates at dentist we must urgent help at short notice eg cancellations. Dad

Texts to Daughter 1

Hi dental chaos do not plan train. Ltr told us our dman gone. We trnsfrd to branch v far away. Nxt txt follows dad
We can not predict evts. Must accept short ntice dats or cancltions. We hve poor teth. Sory. U come nxt yr prhps. Xx dad mum to all

Texts are sent by Daughter 2 over Christmas 2020 wishing her parents a Merry Christmas, thanking them for the money sent to the grandchildren and apologising for not being organised and sending anything. She asks when it would be convenient to call them over Christmas.

Peter's response is

endless excuses. Golden wedding anv ignored by everyone. One card brother this xmas.mum psed off. Letters only now.

Daughter 2 persists and sends a video message on Boxing Day and then texts again on the 19th January 2021.

Peter responds

Tnx for txt. Both well. My fone says it cannot accept your dvd.ours is old two g gsm. Love mum to all xxx.

3.16 The text response sent by Peter to Daughter 2's Christmas text message is very different in its tone to the one sent in January 2021. Similar to the message in October 2017, Peter appears to be angry and requests communication by letter only from Daughter 2.

3.17 It is the Panel's view that the mobile phone was a way in which Peter was exercising control over communications, in this case with family members.

3.18 The Panel noted that Daughter 1 texted June's phone at Christmas 2020 but not Peter's phone despite having communicated with Peter's phone in 2019.

3.19 Whilst it appears that June did not have direct contact with her children, she listed their birthdays along with those of her grandchildren in her diary for 2021. It is poignant that the only photos in the house were those which were kept in a box under her bed. These photos were of family members and it is the Panel's view that this was June's safe space where she was able to keep and look at photos of her family away from Peter.

3.20 Whilst Peter had written detailed notes for the Police, which were found at the property, there were no letters left for the adult children or wider family members.

3.21 Whilst Daughter 2 describes the relationship with her parents as 'estranged' there seems to have been a complete breakdown in the relationship with Son 1 and very little contact with Son 2. Contact with Daughters 1 and 2 is intermittent

and appears to have been controlled by Peter both in terms of responses to messages and delaying planned visits.

4. Key Lines of Inquiry

<u>Line of Inquiry 1:</u> To identify and examine patterns of behaviour, in particular coercive and controlling behaviours as they relate to June and Peter

4.1 Whilst 4 pregnancies in 4 years during the 1970's may not in itself indicate coercive and controlling behaviour the Panel was mindful that repeated pregnancies can be used by a perpetrator of abuse as a means of control and isolation. It is also noted in the antecedent statement that June did not return to work after the birth of her first child, which may have had the effect of her becoming isolated from friends and colleagues and restricting her independence with 4 young children born in such close proximity.

4.2 The information known to the Panel about growing up in the house with June and Peter as parents comes from Son 1's account to the Family Liaison Officer. He recalls a 'hard upbringing' where Peter was very much in control of the family and household and describes June as 'going with the flow'.

4.3 Son 1 describes Peter as a 'monster' and recalls an incident sometime between the ages of 12-16 when his father poured petrol on himself and threatened to set himself on fire.

4.4 It is also Son 1 who reports allegations of non-recent physical and emotional abuse to the Metropolitan Police in 2018, which he didn't feel able to pursue.

4.5 June's sister told the Family liaison Officer that Sons 1 and 2 were made to leave home by Peter when they reached 16 years of age and how it was she who took them in and cared for them.

4.6 Whilst Son 1 describes June as 'going with the flow' the Panel considered how June is likely to have had to develop ways of managing what was happening in the home to keep herself and her children safe. Son 1's perception of her 'going with the flow' may indicate how June managed Peter within the home environment; knowing that if she was to challenge his assumed authority, that she would suffer the consequences.

4.7 The series of injuries presented by June between 1980 and 1995 raised questions for the Panel in relation to how these had happened. Details of the cause of the injuries are not included on all occasions and the injuries include those to her wrist, fractures to ribs, fracture to ankle, fracture of ulna and an injury to the head. Some of the causes of these injuries are noted as *falling downstairs*, *walking into a lamppost* and a *blow* but no further exploration of cause is documented. June presented to different GP practices and hospitals with these injuries where it doesn't appear that the causes of injuries were explored. The nature of June and Peter's frequent movement from accommodation to

accommodation also meant that no one GP practice built a picture of any patterns of injuries and their cause.

4.8 In 2001 Peter tells his GP that he has had a row with his wife. He states that he feels she is expecting too much of him and him feeling too old to do as much as he could when he was younger. He requested joint counselling for him and June and he was provided with the telephone number for Relate. The following year Peter contacts the GP and states that *he is at the end of his tether* following another row with his wife. He tells the GP that he hasn't contacted Relate and doesn't feel suicidal. He is advised again to contact Relate. This is the only reference in agency records to Peter and June's relationship.

4.9 The Panel considered how things appeared and what the reality may have been for June.

4.10 There were a number of options to heat the cottage e.g. log burner and electric heaters however the landlord observed that, on entering the cottage after June's death it was very cold and felt damp with black mould on the walls possibly indicating that the heating hadn't been used. He further stated that he would only see the log burner being used occasionally. Dewis Choice observed that in their experience of supporting older people who had experienced domestic abuse the denial of heating is often used as a means of control.

4.11 The Panel also considered June and Peter's finances and potential financial abuse. June was in receipt of all benefits to which she was entitled, and these were paid into the joint bank account. There was money in this account and a significant amount of cash found in the house after her death however financial costs are documented by Peter as a reason that they cannot move property. Both Dewis Choice and Age Cymru referenced their experiences of supporting older people where there is a pattern of wanting to have money in reserve. Whilst accepting that this can be indicative of older people's behaviours the Panel also noted Dewis Choice's experiences of where money is used as a mechanism by which the perpetrator controls the victim and the victim having to ask and justify any use of funds.

4.12 Whilst there was a television in the cottage the photographs viewed by the Chair showed that it was covered by a blanket at the time of June's death. The television is likely to have been June's only connection to what was going on in the world and it is therefore notable that it was covered.

4.13 The 12 months preceding June's death had been dominated by the Covid 19 pandemic and Government responses and guidance were at the forefront of all news coverage. At the time of June's death in February 2021, Wales was once again subject to lockdown restrictions. The covering of the television could have been a way in which Peter physically blocked out any news or messaging relating to the pandemic.

4.14 It would 'appear' that June had access to heating, television and finances but the Panel questioned whether any of these were actually accessible to June or were in fact controlled by Peter.

4.15 The letters written by Peter that were found by Police at the cottage following June's death create a vision whereby June is completely dependent upon Peter and how she wouldn't be able to function in the world without him;
Just a few years ago Argos for example could be phoned to order anything – now it is 'ONLINE' only. How could my wife cope. She has NEVER put a finger on a computer

My wife fell again in early annuary – how does she get help from A&E when everything day in day out is COVID COVID COVID

It's all gone wrong in recent years

June rushed by me to Hospital to have her inside of her face cut open
She fell on damp steps and shattered her elbow

June is so unlucky. I adored her. I tried so much to help her but as time goes by I am not able to look after her as I could. We were both scared of being alone one day. Everything is getting too much for me.

I should have protected her. She was my best friend. I was her <u>only</u> friend.

I should have protected her.

4.16 This final sentence reflects the isolation in which June lived. Peter perceives himself as June's only friend and indeed Dyfed Powys Police failed to identify any friends or acquaintances for June. The short-term nature and frequent changing of accommodation until 2009, followed by the isolation of the cottage and the fact that Peter was with her wherever she went would have made it difficult for June to establish and maintain any friendships. The panel questioned whether this is what caused June to write about the *horrible, sad and lonely world* in her diary entries on the 12th and 13th January 2021.

4.17 It is the Panel's view that Peter created a version of reality as a way of exercising further control over June; a reality where he is riling against what the world has become, how it's them against the world and how everyone is failing them. His letters reflect this;
It is FUCKING MADNESS that supermarkets sell 'essentials like fags and booze' but the council is boarded up for a YEAR, the GP phone says 999 and the Letting Agent in Christchurch who was once willing to accept us on housing benefit now says when you phone 'DO NOT PHONE EMAILS ONLY PLEASE'

4.18 It is the Panel's view that Peter attempts to create a narrative in his letters where, by killing June he is protecting her from the world as it has become in his eyes.

4.19 His suffocation and strangulation of June is a final and fatal exercise of control, which he attempts to justify in his letters.

4.20 On being told of June's death Peter's brother's response was to ask whether *June been a willing participant or had Peter suffocated her?*

4.21 This comment coupled with the family's decision not to participate in the review raised questions for the panel about what family members knew about the relationship between June and Peter.

4.22 It is the Panel's view that the patterns of behaviour, if viewed in their entirety over the chronology would be indicative of risk associated with domestic abuse e.g. unexplained injuries, suicide attempt, lack of interaction with services/community, isolation from family and community, mental health considerations and Peter's behaviour towards his children. However, the Panel concluded that because these events occur over a significant period of time and June and Peter move frequently no agency sees the pattern as whole and rather individual events are seen as isolated behaviours.

4.23 The Panel acknowledged that the only information available to them was that from agency records and the limited disclosures made by family members to the Family Liaison Officer however it is the Panel's view that it is reasonable to conclude that there was a pattern of behaviour which included physical abuse and coercive and controlling behaviour.

4.24 The Panel also concluded that the pattern of abusive and controlling behaviour had likely occurred for the duration of June and Peter's relationship, which was a period of over 50 years. The control perpetrated by Peter was not one-dimensional but rather he used numerous forms of behaviours including isolation, financial abuse, physical abuse and routines to exercise his control over June. June had lived with and learnt to manage these behaviours for five decades.

4.25 Living with control is described by Professor Jane Monckton Smith as Stage 3 of the Homicide Timeline. She speaks of a 'web of control' that can last a lifetime if there are no challenges to this control or triggers that escalate the behaviour of the abuser[16].

<u>Line of Inquiry 2</u>: To identify which agencies/organisations had involvement with June and Peter in the timeline for the review consider the appropriateness of responses and any services provided

4.26 This section considers the contact that agencies had with June and Peter during the timeline of the review and analyses this contact and any responses.

<u>Health Related Services</u>

4.27 Between 1980 and 1993 June presented to Health services on 6 occasions with injuries including a fractured wrist, bruised and fractured ribs on three occasions and a head injury. The cause of each injury isn't recorded but where a

[16] In Control; Dangerous Relationships and How They End in Murder; Jane Monckton Smith; Bloomsbury 2021

record has been made these include falling down the stairs, bumping into a lamppost, falls and a blow which has caused fractured ribs in 1990 (nature of the blow is not recorded).

4.28 In 2003 when registering with a practice in Carmarthenshire, she ticks that she is worried about a family member and housing/accommodation. Whilst it is noted as good practice that the registration process asks about wider social issues rather than focusing solely on health-related matters there is no record of any follow up conversation with June based on her response to the patient questionnaire.

4.29 A new patient questionnaire is completed in 2012 and again in 2013 with the GP practice in Pembrokeshire. This is the practice that June was registered with until her death in February 2021. From the review of the local GP records, the couple deregistered from the Pembrokeshire practice and moved back to Dorset for a short period between October 2012 and August 2013.

4.30 Following completion of the questionnaire in 2013 June is offered a health check at the surgery which isn't taken up.

4.31 Peter's patient questionnaire completed in 2012, noted that he had *'some mental health problems, anxiety etc in 1990s that no longer apply'*.

4.32 The records between 1st August 2013 and 28th October 2015 note entries related to non-attendance for influenza, pneumococcal and shingles vaccines for both June and Peter. Records note that June did not attend her breast or cervical screening appointments.

4.33 In October 2015, June attended the Emergency Department with swelling to her jaw. An abscess was queried and she was transferred to Maxilla facial services in Swansea. There is no evidence of routine enquiry or consideration of any safeguarding concerns during this attendance at the Emergency Department.

4.34 On 8th May 2016, June attended the Emergency Department following a reported fall. She reported she had slipped on damp steps and the fall was deemed mechanical in nature. June was discharged from hospital after surgery on 9th May 2016. On this admission, routine enquiry was documented in the record and consideration of safeguarding concerns. The response to the routine enquiry was negative and June was not considered as a vulnerable person or at risk of abuse of neglect.

4.35 She re-attended the Emergency Department on 13th May 2016. The record details that her husband had noted bruising to her left upper arm. It was determined this was a post-operative complication. No routine enquiry is evidenced on this attendance.

4.36 In the meeting between the Head of Safeguarding and the Trauma Liaison Nurse and Senior Nurse Manager for Trauma and Orthopaedics, they confirmed

that there was no reason to suspect that the injury and subsequent bruising were not consistent with the explanations given in relation to the fall and her surgery.

4.37 June had three physiotherapy appointments following her admission to hospital before being discharged.

4.38 June subsequently attended fracture clinic on 26th June 2016 where her wounds were re-dressed and the letter to the GP notes *'no concerns'*.

4.39 Further to the above, in the autumn of 2016, June and Peter did not attend for their seasonal flu vaccines.

4.40 The next key event in the records related to Peter's attendance at the Emergency Department on 19th January 2017. He is brought to the hospital by the Welsh Ambulance Service who attend at the cottage following a call by June reporting that her husband had fallen at the property. Hospital records state that he is reported to have fallen after '*slipping down three tiled concrete steps in rented accommodation'*.

4.41 It is noted in the record that Peter is on housing benefit and that he reports inadequate heating in the cottage. He is advised to speak to the council regarding the adequacy of heating and to take the flu jab. He was subsequently discharged and the records note that he had a taxi home.

4.42 The next contact for June was on 2nd June 2017 when she attended the GP surgery. The records detail two elements to the consultation. The records note that June wanted to ensure they had a letter from A&E following her fall in 2016 and she reported that the wire was palpable on her left elbow (related to her surgery in 2016). She was *not concerned, occasionally knocks.* She also explained it was sometimes *pushed out* by body. Options were discussed and it is recorded that June wished to *watch and wait* but would report if it became bothersome and she would be referred back to Trauma and Orthopaedics.

4.43 Secondly, there was a discussion about June's hearing difficulty. She had bilateral compacted earwax and was to make an appointment for syringing which she subsequently attended on 15th June 2017 with the Practice Nurse.

4.44 There are no other concerns noted. It is not known if Peter was present at these appointments.

4.45 Further to this in the autumn of 2017, June and Peter were authorised to have their seasonal vaccines administered. The record does not confirm if they declined administration.

4.46 The next key event was on 22nd February 2018 when June attended the GP surgery. She had a dental abscess at her right upper canine and it is recorded that she could not get to see her dentist until the following day. She was prescribed antibiotics.

4.47 There is another entry in the GP record on 26th February 2018 which relates to a telephone call from June asking for a second course of antibiotics. It is recorded that she was due to see dentist Friday and '*Just worried in case they fail to keep appt (weather) poor mobile signal – needs to see dentist'.*

4.48 On 23rd February 2018, June had attended the dentist with pain and swelling and she subsequently attended for extraction of the affected tooth on 28th February 2018.

4.49 On 27th January 2019, Peter attended the Emergency Department with a swollen face. He informed medical staff he had a filling a few days before. It was suspected he had early cellulitis due to an insect bite and was prescribed antibiotics.

4.50 The review of Peter's dental records confirm that he did attend a dentist for a filling on 22nd January 2019.

4.51 In March 2019, the GP practice received notification that June had not attended for breast screening.

4.52 In the autumn of the same year, neither June nor Peter attended for their seasonal vaccines despite several text messages between September 2019 and March 2020. The practice again received notification in March 2020 that June had not attended for bowel screening.

4.53 On 6th April 2020, Peter contacted the Dental Practice complaining of pain in a tooth. He informed the practice that he had been to the Emergency Department the day before and had been given antibiotics and was requesting more antibiotics. He was given appropriate advice regarding management of his pain.

4.54 The Emergency Department records confirm that he attended the Emergency Department 'COVID' tent on 5th April 2020. The doctor explained that she was not a dentist, noted he had a slightly swollen lymph gland and did prescribe antibiotics with the advice that he contact a dentist the following day. The dental records confirm that Peter contacted the practice on 6th and 8th April 2020 and was given appropriate clinical advice.

4.55 This was the couple's last recorded contact with dental services. Given their frequency of contact prior to this, it may be reasonable to deduce that no further contact was made due to the impact of lockdown and restrictions imposed by the COVID-19 pandemic.

4.56 In July, September and October of 2020, the GP Practice sent text messages to June and Peter for their seasonal vaccines. On 23rd October 2020, the Practice tried to ring Peter to offer the flu vaccine, but there was no reply and they left a message.

4.57 On 27th October 2020, there is a letter in both June and Peter's GP records signed by them both asking the Practice to delete their mobile phone number

from their records as this phone was no longer in use. The letter states that the *property is rented and has no BT phone line. It is in a POOR RECEPTION mobile phone area. So any use of a mobile can only be some distance away from us. It is not the best of situations but being on Benefits it is all we can presently afford. Should it be essential to contact us perhaps writing a letter is the only option*.

4.58 Despite this, they were sent a text message again regarding the vaccines on 30th October 2020. On 3rd November 2020, it is recorded that they both declined consent for short message service (SMS) text messaging.

4.59 On 15th January 2020, Peter was authorised to receive his COVID 19 vaccine. On 26th and 29th January 2021, the surgery recorded they tried to contact Peter by phone, despite the letter received on 27th October 2020 and there was no answer when they tried to contact him. They have confirmed that they subsequently sent him a letter on 26th January 2021.

4.60 June's authorisation for the vaccine is recorded on 2nd February 2021. On 3rd February 2021, it is noted that both of them refused to start or complete the course. The Practice have been unable clarify the means by which they tried to contact June for her COVID-19 vaccine.

4.61 The GP Practice have advised that the only time that a read code for "refusal to start or complete a course" is entered in the patient record is if a patient phones the practice or attends the practice and advises a member of staff. They assume therefore that Peter would have phoned the practice following receipt of his letter to decline their offer.

4.62 Phone records show that the GP practice called Peter's mobile on the 9th February 2021 but left no message. On the 8th February 2021 there is a record of an outgoing call from Peter's phone to the Dental Practice. This call is followed shortly by a text message confirming an appointment with the Dentist on 31st March 2021. Three further calls are made to the Dentist following this text message and whilst the record shows that the last call at 10.31hrs was answered there is no record of the conversation.

4.63 June notes in her diary on the 5th January 2021 that she has fallen. There is no detail of the fall or the extent of any injury. Peter also notes this in one of his letters found in the cottage after June's death;
My wife fell again in early January – how does she get help from A&E when everything day in day out is COVID COVID COVID

4.64 There is no evidence in phone records or agency records that any medical advice was sought following June's fall. This is explored further in relation to Line of Inquiry 5 below paragraph 4.117.

4.65 It is the dental practice that June has most contact with during the timeline of the review attending 25 appointments at 2 dental practices between 2012 and her last appointment on the 19th February 2020. These appointments included routine examinations and appointments in response to acute pain.

4.66 There is nothing in the dental records indicating any safeguarding concerns and staff did not recall any concerns during interviews for the IMR or with the Chair.

4.67 Dental Care was the primary care service that the couple regularly attended for preventative and acute treatment. This contrasts with engagement with GP where there is a pattern of non-attendance for preventative health care screening/vaccinations however, medical attention is sought for acute pain with the exception of June's fall in January 2021. It is the Panel's view that attendance at the Dentist may have been seen by Peter as non-authoritative/threatening compared to the GP who may have been considered an authority figure who may have asked questions and intervened. The Panel concluded that Dental Practices provide an opportunity for identification and disclosure by individuals who may not access or feel comfortable in more formal health settings and the establishment of DRiDVA, a model of the IRIS project in Dental Practices in England was noted by the Panel.[17]

Dorset Police

4.68 Peter reported an incident to Dorset Police whereby he alleged that he was punched to the right shoulder and hit on his back by a local farmer. The incident had occurred after the farmer dumped manure against a fence abutting Peter's property. Peter went into the field to take some photographs in order to complain and an altercation took place with the farmer. The farmer made counter allegations and no charges were brought against either party.

Dyfed Powys Police

4.69 Dyfed Powys Police have four recorded incidents linked to June and Peter other than the reports of June's death.

- On the 18th January 2013, Dyfed Powys Police receive a call regarding an abandoned vehicle due to snow close to the cottage. The owner of the vehicle was contacted. The vehicle owner had no relationship to cottage or June/Peter.
- On the 9th February 2013, police receive a call from Welsh Ambulance Service reporting an 85yr old female having fallen at the cottage address and caller is swearing and being very aggressive to ambulance. Details of caller unknown. Police initially responded however stood down by ambulance and did not attend at the cottage. The Welsh Ambulance Service have no record of this incident.
- On the 3rd March 2018, police receive a call from Peter reporting person or persons unknown had dumped a load of snow in front of his access. Caller initially very irate on the phone stating everyone in Wales was incompetent. Caller stated he was ex-army and had gone into survival mode. Caller concerned that should he or his wife need assistance they could not get out

[17] https://www.bristol.ac.uk/dental/news/2017/dridva.html

nor emergency vehicles in. Safeguarding advice provided and caller reported to be relatively calm at end of call.

- On the 4th December 2020, Dyfed Powys Police received a call from the Property Management Company as occupants of the cottage had reported an abandoned / damaged vehicle near to cottage. Owners contacted to arrange removal. The owners of the vehicle had no relationship to June/Peter or the cottage.

4.70 The calls in 2013 and 2018 record Peter's behaviour as *swearing and very aggressive* and *very irate*. Peter is also recorded as saying that *everyone in Wales was incompetent.*

<u>Line of Enquiry 3</u>: Opportunities to identify and respond to domestic abuse

4.71 Whilst the Panel concluded that it is likely that June experienced abusive and controlling behaviours for the duration of her relationship with Peter, they were less certain that she would have identified these behaviours as abusive or controlling. Due to her living with these for over 50 years these had potentially become normalised for her and were behaviours that she had learnt to manage. This is not uncommon for older women who have experienced domestic abuse over a prolonged period of time.

4.72 The Panel has seen no evidence in agency records that June made any disclosures or sought help from agencies at any time however it is noted that during the period that June presented with unexplained injuries between 1980 and 1993 there was no proactive routine enquiry and culturally domestic abuse was still a taboo subject both within professions and society. In the event that June had made a disclosure or sought help during this time and had a negative response and/or experience she is unlikely to have sought help again and is more likely to have developed her own coping mechanisms, including not making further disclosures, not seeking help and managing the home environment to the best of her ability to safeguard herself and her children.

4.73 Having developed and employed these coping mechanisms for decades it is likely to have taken specialist intervention and an investment of time for June to have identified the behaviours as abusive.

4.74 A primary reliance on older people recognising and identifying themselves as victims of domestic abuse presents a challenge both in terms of how practitioners identify and respond and the service models to support older people.

4.75 The panel considered what opportunities there were in the timeline to speak with June and potentially identify what was happening at home and in her relationship with Peter. The key opportunities are listed below:

- June attended at the **Emergency Department** twice during the timeline: The first in **October 2015** when she presented with swelling to her left jaw and following an assessment was transferred to Swansea for surgery where she remained for 2 days. The second was in **May 2016**, when she attends at the

Emergency Department having fallen in the cottage and injuring her left elbow. During her attendance at the Emergency Department in May 2016 a routine domestic abuse enquiry is undertaken and a negative response is noted on her record. June is not identified as a vulnerable person or being at risk of abuse or neglect. June is admitted to hospital and has surgery to her elbow. June has three physiotherapy appointments before being discharged from the service. The physiotherapy notes record that *'social and family history – gardening and cooking* but there is no indication that any further enquiry is made in relation to domestic abuse. Routine enquiry for midwifery and health visiting was introduced in Wales in 2005 and since then it has been rolled out in Emergency Departments. Routine Enquiry involves asking all women at assessment about domestic abuse regardless of whether there are any indicators or suspicions of abuse. There is no record in either Health Board records that routine enquiry was carried out with June following her presentation at the Emergency Department in 2015 and subsequent procedure. Hywel Dda University Health Board has identified that the routine enquiry about domestic abuse is not as embedded in practice in the Emergency Department for all patient pathways.

- June only visits her **GP Practice** on three occasions during the timeline considered by this review, the first in **June 2017** when she wants to confirm that the GP has received information from the hospital in relation to the surgery the previous year and to discuss an ear condition. She attends an appointment the week after to receive treatment for the ear condition. She attends again in **February 2018** with a dental abscess. These are the only confirmed attendances at the surgery and there is no record of routine enquiry being undertaken on either occasion. Hywel Dda University Health Board has identified the challenge presented by the fact that there is no statutory or policy requirement for GPs to routinely enquire about domestic abuse.

- It is the **dental practice** that June has most contact with during the timeline of the review attending 25 appointments at 2 dental practices between **2012 and** her last appointment on the 19th **February 2020**. There is nothing in the dental records indicating any safeguarding concerns and staff did not recall any concerns during interviews for the IMR or with the Chair.

4.76 There is no record in the Hospital, GP or Dental records indicating whether June was accompanied during her appointments but based on June's own account to the landlord it would have been Peter who drove her to these appointments. Staff at the Dental Practices recall June attending all appointments with Peter. Whether June was accompanied during the actual appointments is relevant, as this would have created an opportunity for June to have been spoken to on her own and ensure that her own voice and needs could be heard.

4.77 Hywel Dda University Health Board has identified a recommendation to communicate expectations in relation to the importance and means of recording whether patients attend alone or are accompanied during presentations/consultations across acute, community, primary care and mental health services.

4.78 When considering the opportunities for disclosure and identification of domestic abuse amongst older women the Panel was mindful that the main agency for older women to disclose their experience is within health-based settings. Hywel Dda University Health Board currently operates Routine Enquiry and Ask and Act and examines the challenges presented by both approaches in their Individual Management Report.

4.79 Ask and Act is a process of targeted enquiry across the Welsh Public Service introduced by Welsh Government to complement the process of routine enquiry within Midwifery and Health visiting, Mental Health and Emergency Departments[18]. The term 'targeted enquiry' describes the recognition of indicators of violence against women, domestic abuse and sexual violence as a prompt for a professional to ask their client whether they have been affected by any of these issues.

4.80 The aims of "Ask and Act" are:

- to increase identification of those experiencing violence against women, domestic abuse and sexual violence
- to offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client
- to begin to create a culture across the Public Service where addressing violence against women, domestic abuse and sexual violence is understood in the correct context, where disclosure is accepted and facilitated and support is appropriate and consistent
- to improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health; and
- to pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.

4.81 "Ask and Act" is one of the most significant practice changes, facilitated through the Welsh Government's National Training Framework on violence against women, domestic abuse and sexual violence. These two Welsh Government policies are integrated, in that local delivery of the National Training Framework also delivers key aspects of "Ask and Act".

4.82 The National Institute of Health and Care Excellence (NICE) and the World Health Organisation recommend a system of targeted clinical enquiry across Health and Social Care to better identify and therefore respond to domestic

[18] https://gov.wales/identifying-violence-against-women-domestic-abuse-and-sexual-violence-ask-and-act

abuse.[19][20]An independent evaluation of Ask and Act was published in January 2022[21] made the following findings;

- It is seen as an important and valuable programme which is having an impact across Wales for those participating, both individually and at an organisational / sector level;
- There is wide recognition of the need for Ask and Act and broad support for the aims of the programme;
- Delivery of Ask and Act is complex and common challenges to effective delivery were observed across relevant authorities, particularly relating to capacity and funding.

4.83 Hywel Dda University Health Board alongside other relevant authorities in Mid Wales including Local Authorities and Fire and Rescue Service are required to implement the National Training Framework and Ask and Act as part of their duties under the Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015. To date, 27,428 practitioners in the Mid and West Wales region have received Group 1 training to raise awareness of violence against women, domestic abuse and sexual violence with 1697 Ask and Act practitioners across the region.

4.84 Ask and Act relies on practitioners identifying triggers within an individual's response/behaviours to then proactively ask questions to identify and respond to experiences of domestic abuse. This is a different approach to routine enquiry, which by the nature of its name is a routine enquiry of each patient presenting at a Health based service.

4.85 When considering June's presentations in the timeline of the review there were no indicators that would have triggered the Ask and Act pathway.

4.86 A recommendation was made in a previous Pembrokeshire DHR (2018) that

GPs should be a priority for Ask and Act training.

4.87 Whilst the National Training Framework and application of Ask and Act is being rolled out within core services the Health Board representative on the Panel outlined the challenges in embedding the training in contracted services within Primary Care namely GP practices.

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[19] Responding to Intimate partner violence and sexual violence against women. World Health Organisation clinical and policy guidelines (2013)

[20] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE public health guidance 50 (February 2014)

[21] https://gov.wales/sites/default/files/statistics-and-research/2022-01/evaluation-ask-and-act-685.pdf

4.88 The Practice at which June was registered acknowledged they had not completed Group 2 Ask and Act training in accordance with the VAWDASV National Training Framework. They stated they had not heard of this training despite it being available in the Health Board since 2019. Further to this, dedicated training was made available to General Practices in September 2020. Having identified this as an immediate action the Practice completed the relevant training during the course of this review.

4.89 Prior to 2019, awareness of identifying and responding to domestic abuse was incorporated in other Safeguarding training – adults and children, delivered by the Health Board's Safeguarding Team. Additionally, a representative from the Older Persons Commissioner's Office delivered several bespoke training sessions on 'Domestic Abuse and Older persons' throughout all three counties within the Health Board in 2018 and 2019. We do not know the uptake from primary care in response to this training. As independent contractors, they do not have an Electronic Staff Record, which records all mandatory training for Health Board employees.

4.90 It is the view of the Panel that the reliance of Ask and Act on an individual practitioners' judgement presents a challenge to a consistent application across public services and the potential for bias (conscious or unconscious) to influence a practitioners' response.

4.91 It is the view of the Panel that enquiries for domestic abuse need to be simple and straightforward and remove responsibility from an individual practitioner. It is also the view of the Panel that Health based enquiries should be routine and mandatory rather than targeted and subject to an individual's judgement.

4.92 Whilst Dental Practices fall within the remit of Primary Care it is unclear how the current Ask and Act guidance and the wider National Training Framework relates to Dental Practices and how this would be implemented.

4.93 Whilst there are safeguarding policies and procedures in place within both GP and Dental Practices the IMR highlights that existing Quality Assurance frameworks and training requirements for staff working in these settings are not aligned with intercollegiate documents for safeguarding nor the National Violence against Women, Domestic Abuse and Sexual Violence training framework.

4.94 The Panel identified the following elements as key components in improving the identification of older people who are experiencing domestic abuse:

- Training

  There is a lot of training that needs to be done for professionals as understanding of older people's experiences of domestic abuse is lacking[22]

[22] https://www.olderpeoplewales.com/Libraries/Uploads/Leave_no-one_behind_-_Action_for_an_age-friendly_recovery.sflb.ashx

Whilst practitioners in relevant authorities are required to complete the relevant elements of the National Training Framework it is the Panel's view that there is a need for training that is tailored to the needs and experiences of older people. This training, which should be delivered by specialist providers should including exploring the experiences of older people and the link between domestic abuse, dementia, other cognitive impairments and mental health in addition to safeguarding and support options. Training should be complemented by a range of resources that practitioners can access. In 2021, Mid and West Wales Safeguarding Board made a range of resources from the Dewis Choice Project available on its website for professionals to access to support continued professional development[23]

- Awareness raising

The language, imagery and rhetoric about VAWDASV used in publicity campaigns and literature fails to convey the experiences of older people[24]

It is the Panel's view that there is a need to generate discussions with the public and practitioners about older people's experiences of domestic abuse. Raising awareness of older people's experiences of domestic abuse appears to be an uncomfortable discussion for society and there is a need to bring these conversations to the fore through raising public and practitioner's awareness alongside that of older people to recognise abusive behaviours. In her recent report the Older People's Commissioner for Wales makes a recommendation to: *Raise awareness of risk and abuse (experienced by older people) and where to go for support through media and via public bodies and networks[25]*

Working in partnership with the Older People's Commissioner for Wales the Regional VAWDASV Partnership launched a campaign during National Safeguarding week in November 2021 targeted at practitioners working with older people to raise awareness of their experiences. The campaign included social media posts #GetHelpStaySafe and #YouAreNotAlone and the distribution of over 1000 copies of the Get Help Stay Safe leaflet produced by the Older People's Commissioner. Braille and British Sign Language versions of this leaflet are also currently being developed.

The Regional VAWDASV Partnership is working with survivors across Mid and West Wales to co-design an awareness campaign targeted at older

[23] https://www.cysur.wales/dhr-learning-materials/

[24] Report into the Support available in each local authority area in Wales for Older People experiencing Violence against Women, Domestic Abuse and Sexual Violence 2021 (Inside Out Organisational Solutions Dr. Norma Barry and Rhian Bowen-Davies)

[25] [25] https://www.olderpeoplewales.com/Libraries/Uploads/Leave_no-one_behind_-_Action_for_an_age-friendly_recovery.sflb.ashx

people who are experiencing domestic abuse on where and how to access information and support.

In developing this campaign particular attention will be given to the language used to ensure that older people and members of the public can identify with the messages. This information will be made available in community settings accessed by older people including GP surgeries, pharmacies, libraries, community centres and supermarkets.

Dewis Choice's approach within the region has included working alongside community-based groups including carers, cancer survivors and women's groups to introduce the concept of healthy relationships in later life. This approach has proved successful in engaging older people in conversations about relationships and the identification of abusive behaviours.

- Early Intervention: IRIS
  The IRIS (Identification and Referral to Improve Safety)[26] programme is a training, referral and advocacy model to support clinicians to better support their patients affected by Domestic Violence and Abuse and to increase the awareness of domestic violence and abuse within general practice. IRIS provides specialist domestic violence and abuse training to clinical professionals and administration staff within local general practices. The training supports clinicians to recognise and respond to domestic violence and abuse,and the programme provides a direct and trusted source for advocacy for patients following disclosure. The IRIS programme is an evidence-based, effective and cost-effective intervention to improve the primary care response to domestic violence and abuse and is nationally recognised.

  IRIS is cited by the Department of Health as the best practice for a primary care response to DVA (2010, 2011, 2017), and IRIS informed the NICE guidance and standards on DVA (2014 and 2016).

  In a previous DHR commissioned by Pembrokeshire Community Safety Partnership (2018) a recommendation was made for **Pembrokeshire to become an early adopter site for IRIS in Mid and West Wales by 2019.**

  In response to this recommendation, Hywel Dda University Health Board approached GP clusters in Pembrokeshire, Ceredigion and Carmarthenshire to scope their willingness to participate in a pilot of IRIS. Carmarthenshire has now been identified as the pilot area and a specialist provider has been commissioned to provide Advocate Educators. The pilot is being funded by Hywel Dda University Health Board.

  Carmarthenshire is the first of the four Local Authority areas in Mid and West Wales to pilot IRIS however its application within GP practices across Wales is inconsistent and very much a post code lottery. It is the view of the Panel that IRIS should be mandated across all GP practices in Wales and resourced by Welsh Government in line with its commitments to early intervention and

[26] https://irisi.org/our-projects/#IRIS

prevention in the National Violence against Women Domestic Abuse and Sexual Violence Strategy.

- Ask Me and other community-based responses to Domestic Abuse

We know that communities are often the first to know about abuse, and that they can act as gate openers or gate closers in terms of help seeking[27]

Survivors of domestic abuse are likely to confide in people they know and trust. This can include friends, family or people within their community.

But a lack of understanding and confidence can result in people being unsure of how to respond when someone discloses abuse and survivors can feel judged, isolated or silenced by the people around them.

The Ask Me project, run by Welsh Women's Aid supports communities to give a better response to survivors but also to be proactive in finding ways to challenge unhelpful myths, attitudes and stereotypes that enable and normalise abuse.

The Ask Me project provides free and ongoing support that helps community members to start conversations about abuse, know where help is available, share their knowledge with others and to know how to give a supportive, helpful response to anyone who shares their experience of abuse.

The Ask Me scheme operates in some parts of the Mid and West Wales region but not in Pembrokeshire. In a previous DHR undertaken by Pembrokeshire Community Safety Partnership (2018) there was a recommendation to **Roll out Ask Me in Pembrokeshire**. Whilst initial discussions were held with Welsh Women's Aid in 2018 this has not been implemented in Pembrokeshire. The Chair questioned the Panel as to why this recommendation had not been implemented and Panel representatives referred to the learning from the sites in Mid and West Wales relating to time and resource commitments as well as what were considered to be prohibitive costs of the programme if implemented regionally.

Whilst the Ask Me scheme hasn't been implemented, an alternative approach was piloted in Mid and West Wales in 2021, focused on the Health and Beauty Sector. 5 webinars, facilitated by the specialist violence against women, domestic abuse and sexual violence sector were hosted for practitioners aimed to raise awareness and support appropriate responses and signposting. A podcast[28] was also developed as part of this approach along with materials for the Live Fear Free helpline distributed to beauty industry professionals and salons. This work is being extended to include Barbers and other venues to address attitudes and behaviours whilst also being able to signpost to specialist support services.

[27] Finding the Costs of Freedom report, 2014

[28] https://podcasts.apple.com/us/podcast/what-next/id1489192748?uo=4
https://open.spotify.com/show/3WmAwK1WfaqcU78A9D4bo5

- Perpetrators of Abuse
  It is the Panel's view that more focus is needed on targeting perpetrators of domestic abuse against older people both in terms of opportunities to identify and address their behaviours and as a mechanism for services to gain access to households. Dewis Choice has identified that in many cases such as June's, it is the perpetrator who has the contact with and engages with agencies and the outside world and the project has found that the perpetrator is more likely to agree to services if they are seen to benefit from them.

- Bespoke and specialist support for older people who are experiencing domestic abuse
  The Older People's Commissioner for Wales report[29]concludes that generic violence against women, domestic abuse and sexual violence services are not equipped to respond to the needs of older people experiencing domestic abuse with service models and interventions tailored to the needs of younger people and failing to take account of the needs and experiences of older people.

  The report further concludes that older people feel less able to access support that is available for a number of reasons, such as unawareness of support services; a perception that support is not available for older people; financial dependence on the abuser; a sense of shame or embarrassment; perceived lack of entitlement to support: fear of the consequences of reporting abuse and a perceived ageism amongst professionals.

  Based on a growing understanding of the prevalence and experiences of older people who are experiencing domestic abuse, the demographics of the Mid and West Wales region and the number of domestic homicides in the region involving older women, it is the Panel's view that commissioners of violence against women, domestic abuse and sexual violence services in Mid and West Wales should ensure that services can provide a bespoke, tailored response to meet the needs of older people who are experiencing domestic abuse. Commissioning of services should be in line with the principles outlined in Welsh Government guidance[30] and the regional service specification developed by the Mid and West Wales Violence against Women, Domestic Abuse and Sexual Violence Partnership.

4.95 When applying the approaches and activities above to June's circumstances the Panel concludes that;

[29] Report into the Support available in each local authority area in Wales for Older People experiencing Violence against Women, Domestic Abuse and Sexual Violence 2021 (Inside Out Organisational Solutions Dr. Norma Barry and Rhian Bowen-Davies)

[30] https://gov.wales/sites/default/files/publications/2019-05/statutory-guidance-for-the-commissioning-of-vawdasv-services-in-wales.pdf

- Due to June's experiences of controlling and abusive behaviours over five decades this had become her 'norm' and she is unlikely to have identified as a victim of domestic abuse;
- June is unlikely to have related to terminology of 'domestic abuse' and there is a need to think differently about awareness raising targeted at older people in terms of language and terminology;
- Due to language, possible previous negative experiences of help seeking or due to Peter being present at appointments June is unlikely to have had the opportunity or felt safe to respond positively to a routine or targeted enquiry by practitioners on a first contact (and there is no record of a repeated or follow up enquiry in the contacts she has with health practitioners);
- June's only contact with society appears to have been the twice-weekly shopping trips with Peter. Whilst most of the time on these trips is spent with Peter, there are occasions when she is likely to have been on her own and may have had access to information that was displayed in public settings such as supermarkets, libraries, pharmacies and shops. These locations could provide opportunities to display information that resonates with older people in terms to their relationships, safety and well-being and where help and support could be sought.

<u>Line of Inquiry 4</u>: Whether and to what extent mental health issues contributed to the circumstances leading to the death of June?

4.96 Daughter 2 states in the antecedent statement; *My dad suffered with anxiety and was highly sensitive to stress and noise. I believe my mum had depression but it was never really spoken about*

4.97 The Hywel Dda University Health Board IMR summarises the information noted in Peter's health records relevant to his mental health as follows;
Some indication that Peter suffered from anxiety and PTSD however in a lot of cases this diagnosis is self-reported and there is no detailed information that would support this diagnosis.

In 1995, in Peter was referred for counselling. It would seem that in his words, 'the loss of his parents and other past events reinforced his doubts and need for caution, that his military background forced him to ignore nothing and worry about the unknown'. In one report it was noted that he was struggling with issues of power and control. It was noted by the counsellor that it was 'jumbled' and they were trying to 'sort it out' but there is reference to his own powerlessness and perceiving others as having power over him, for example, the DHSS.

It was self-reported to the GP in 1998 that he was having severe panic attacks after a security alarm was activated in his local library and some evidence to support this in the response from the library to Peter that there had been an incident but was limited around details of the incident. A copy of this letter is in his GP record.

From the GP records, Peter was prescribed Diazepam and anxiolytics that would help reduce anxiety and panic, and an anti-depressant medication. There is

however no detail in the records regarding when the medication was stopped and what the management plan was regarding his mental health.

There is reference to having a long history of PTSD since leaving the army in 1960s, but nothing to indicate who had diagnosed this and no copies of any assessments undertaken. The notes refer several times to periods of high anxiety relating to noise from military aircraft, firing range and as such requesting to move house.

When he registered with the GP practice in 2012, Peter noted a history of "some mental health problems, anxiety etc in 1990s that no longer apply.

4.98 Family members informed the Family Liaison Officer that Peter's father had taken his own life and his mother had died from cancer.

4.99 There is a note in Peter's medical records of an attempted suicide in 1985 but no further details are included. Son 1 also recalls an incident when he was a teenager when Peter poured petrol on himself and threatened to set himself on fire.

4.100 From Peter's medical records it appears that he experienced challenges living in populated areas. In 1995 he wrote a number of letters to his GP requesting support to move accommodation stating that he couldn't live in cities or near people. On the GP registration form completed by Peter in 2003 in Carmarthenshire he ticks that he has depression and notes that they have moved there on medical grounds. In 2006, a letter is provided by Peter's GP in Dorset supporting his housing application as a result of stress and insomnia caused by noisy neighbours.

4.101 Letters written by Peter are included within his medical records and the Panel has had sight of the letters written by Peter that were found in the cottage when Police attended after June's death.

4.102 There is a pattern to the letters written by Peter over the years. All are handwritten and in a number of them capital letters are used and words/sentences are underlined with a ruler for emphasis. Some letters to the GP are signed only by Peter but most are signed by both Peter and June.

4.103 The tone and language used by Peter in the letters found in the cottage suggest an escalation in Peter's frustrations and anger at the outside world;

There is <u>NO</u> BT line to this cottage and <u>NO</u> signal inside or near the cottage. Even the BLOODY DOCTOR could not accept or understand our problem.

Three years ago our pretty red fiat Panda suddenly CUT OUT on the Haverfordwest PMS roundabout…..it was due to the <u>crap civilian</u> rubbish computerised ignition/control unit !!

It is FUCKING MADNESS that supermarkets sell 'essentials like fags and booze' but the council is boarded up for a <u>YEAR</u>, the GP phone says 999 and the Letting

Agent in Christchurch who was once willing to accept us on housing benefit now says when you phone 'DO NOT PHONE EMAILS ONLY PLEASE'

My wife fell again in early January – how does she get help from A&E when everything day in day out is COVID COVID COVID

A few days ago June and I discovered that I have a lump by my right nipple. How should I seek help for that?

Letting agents can demand 6 months rent in advice + 5 weeks rent as deposit to applicants receiving Housing Benefit

COTTAGE is no longer suitable for us

Plus removal costs + new beds etc

4.104 Some of his reasoning appears irrational and he appears to draw on unrelated events to try and make points. His frustrations in relation to his and June's health and housing needs, Covid and perceived limited access to services are evident in his letters.

4.105 His language in these final letters is also an escalation from previous letters where *bloody* was the strongest language used compared to *FUCKING MADNESS* in the last letters.

4.106 In response to Covid the world was operating in a way that was far removed from what Peter was comfortable and felt he had control. When referring to his medical notes in 1995 it states that Peter had issues with power and control and in particular the sense of others having control over him. It is the Panel's view that the changes to everyday life enforced by Covid left Peter feeling both out of his comfort zone and control and that this sense of a loss of control may have resulted in a deterioration in Peter's mental health. This perceived loss of control may have triggered a change in Peter's mind-set which are again stages identified in the Homicide Timeline.[31]

4.107 In his attempts to justify his murder of June he also attempts to deflect his inability to cope or adapt to the changing world onto June saying how it is she who is unable to cope; *How could my Wife cope. She had NEVER put a finger on a computer.*

4.108 There is a sense of morbidity in how Peter responds to finding the lump on his chest. On the 8th February 2021, he leaves a voicemail for the Property Manager stating that he has a medical emergency as he had found a *lump on his right tit*. He further stated that he would likely need to move from the property into nursing care accommodation and he absolutely couldn't have anyone attend at the property for at least the next few weeks.

[31] In Control; Dangerous Relationships and How They End in Murder; Jane Monckton Smith; Bloomsbury 2021

4.109 On the 10th February 2021, Peter has a conversation with the Property Manager where he says that he may have jumped the gun a little as he hadn't seen a doctor regarding the lump.

4.110 On the 9th and 10th February 2021 June notes in her Diary that *Peter has cancer.* Peter has, by his own account to the Property Manager not seen the GP and there is no evidence that he had attempted to contact the GP regarding the lump and yet June writes that he has cancer.

4.111 It is the Panel's view that Peter created a narrative and this that wasn't reflective of reality. This narrative can be seen in relation to finances, his and June's ability to move, his health and the narrative he created around access to services. He was aware (due to previous attendance) that services were open and accessible however, this does not suit his narrative. Being isolated with limited contact with people and potentially limited access to television and radio it is likely that Peter's reality also became June's as she had no means to balance this with outside information.

4.112 It is the Panel's view that having previously experienced anxiety it is likely that the changes in day-to-day life as a result of Covid including prolonged restrictions, practical changes to their routines and digitalisation of services contributed to a deterioration in Peter's mental health which is reflected in the language, tone and content of his letters. Having previously self-reported his history of anxiety to his GP there is no evidence that Peter recognised any deterioration in his mental health nor that he attempted to seek medical advice.

4.113 The Panel note however that regardless of whether there was a deterioration in Peter's mental health June's murder was meticulously planned. Peter had written and posted letters to the Sorting Office including detailed directions to the property. He had provided written notice to the Property Management Company and left detailed instructions to Police who attended the property in relation to who to notify of their deaths and funeral plans. The planning of and carrying out the homicide are the final stages of the Homicide Timeline.[32]

<u>Line of Inquiry 5</u>: Examination of the experiences of older people and particularly those living in rural communities of accessing information and services during the Covid 19 pandemic and the impact of Covid 19 on the availability of information and the responses, reach and accessibility of services to older people in rural communities

<u>Access to services</u>

4.114 Information contained within Hywel Dda University Health Board IMR documents the accessibility of GP and other health services during COVID; *The surgery confirmed that they were accessible throughout the pandemic. They were available by telephone and while their doors were closed, they were never locked. They advised that there was communication via the media and social*

[32] In Control; Dangerous Relationships and How They End in Murder; Jane Monckton Smith; Bloomsbury 2021

media, but it is not known what access to internet, social media and television, newspapers, etc. June and Peter had.

The GP Practice further referred to the role of Community Connectors, during the pandemic. It is suggested this requires further exploration to understand how the public would have known about the service and how to access them.

Dental practices were accessible for advice during the pandemic and dental advice could also be sought via the 111 service.

Emergency Departments remained open.

4.115 During a meeting with the GP practice to understand the service 'offer' during the pandemic the Chair was able to ascertain that:

- Apart from the initial two weeks immediately after lockdown announced in March 2020 the practice was open;
- Patients would be offered a telephone triage which was reviewed by the GP and face to face appointments would be offered if required;
- GPs worked throughout the rest of lockdowns and firebreaks;
- Information about how to access the surgery was displayed in surgery windows and online/social media;
- The phone message at the surgery was changed to explain requirements regarding phone triage prior to a telephone consultation with a GP.

4.116 In relation to Dental Practices, the Chair met with representatives of the two practices that June and Peter attended. They confirmed that phone lines remained open during lockdowns and telephone triage was undertaken with any patients who contacted the practice. The answerphone messages in both practices explained the triage process. Information about how to access the services was displayed in the practice windows and sent to registered patients via email and automated text service.

4.117 The Practices explained the change from a proactive recall system that was in operation prior to Covid where automated text messages were sent to patients to book an appointment to a 'reactionary' system during Covid, which relied on patients contacting the practice. The Practices acknowledged that there weren't many outgoing communications to patients during lockdowns or whilst restrictions were in operation.

4.118 Peter contacted the dental practice for advice on the 6th and 8th April 2020 following his attendance at the Emergency Department Tent on the 5th April. This was during the first national lockdown period. Further examination of phone records show that Peter contacted the practice on 8th Feb 2021 (4 calls between 9.56 and 10.31 hrs). It appears that this was to make an appointment as a text is received that same day confirming an appointment for 31st March 2021. This contact with the practice once again highlights the priority given to dental care by Peter and June seen throughout the chronology.

4.119 When the first national lockdown in response to Covid 19 was announced in March 2020, Local Authorities, Health and other services were driven to implement changes to service delivery models overnight which led to an acceleration in the digitalisation of information and access to services. For both GP and Dental Practices there is learning in relation to the accessibility of information, much of which went online. Given the age profile in Pembrokeshire there was the potential for this approach to exclude some groups of people including older people, those who are economically disadvantaged and those with limited or no digital access. The Older People's Commissioner for Wales report *Leave No-one Behind* (2020), concludes that it is possible there were assumptions that people would know that health services were available to access during the pandemic.

June and Peter's Experience of Accessing Services

4.120 When June falls on the 5th January 2021 there is no evidence of attempts to seek medical advice whether this be the GP, 111 or the Emergency Department. In his letter Peter states: *My Wife fell again in early January – how does she get help from A&E when everything day in and day out is COVID COVID COVID.* It appears to be Peter's perception that A&E services can't be accessed despite him attending A&E in April 2020 during the first lockdown.

4.121 There are further references to health concerns in respect of the lump that Peter finds. This seems to be what June refers to in her diary entries 9th and 10th February and Peter also refers to this in his text and telephone call with the property manager on the 8th and 10th February. Peter tells property manager that he hasn't even seen a doctor in relation to the lump.

4.122 In the letter written by Peter he expresses his frustration with what he feels was the inaccessibility of health services during this period quoting *GP phone says ring 999*. This is the standard recorded message for GP surgeries as they introduce a range of options to guide patients to the most appropriate response. There is however, no evidence in phone records that Peter made any attempts to contact services during the period after June's fall in January 2021 or in relation to the lump he discovered. When this is considered alongside the content of Peter's letters, it is the Panel's view that, despite Peter accessing services for acute pain during the pandemic, writing to the GP practice in 2020 and proactively contacting the Dentist for appointments in 2021 the narrative he created was one where services were not accessible.

4.123 This is reflective of the findings in the Older People's Commissioner for Wales report, which states that; *many older people afraid of the risk of contracting Covid 19 have stayed away from the GP practice and hospitals. This means that many older people will not have been able to access the health care services and support they need*[33]*.*

4.124 There was no evidence that June and Peter read newspapers and as stated previously the television was covered by a blanket at the time of June's death

[33] https://www.olderpeoplewales.com/Libraries/Uploads/Leave_no-one_behind_-_Action_for_an_age-friendly_recovery.sflb.ashx

possible indicating that access to the television was limited or controlled**.** There was no computer at the cottage and Dyfed Powys Police were able to confirm that neither of the phones used by June and Peter were smart phones capable of internet access.

4.125 Daughter 2 stated that her parents *didn't like society and covid scared them.* Limiting access to the news may have been a mechanism by which Peter minimised news of covid especially when his view was that *everything day in day out is COVID COVID COVID.* June didn't have access to information available online or via the television as this is likely to have been controlled by Peter.

4.126 The Older People's Commissioner report highlights that 41% of people over the age of 75 years of age in Wales do not have access to the internet and *the pandemic has highlighted a stark digital divide in Wales as well as the significant impact that digital exclusion can have on many aspects of people's lives.*[34]

4.127 At the beginning of the pandemic, a multi-agency Covid Communication Hub was established to coordinate messages across the Hywel Dda University Health Board area. This Hub included representatives from Dyfed Powys Police, Hywel Dda University Health Board and Local Authorities. This Hub produced information via press releases, media, radio and local newspapers to compliment the national information campaigns being led by Welsh Government. The Panel acknowledge however that it is unlikely that June had access to any of these forms of communication.

4.128 In addition to the communications via the Hub, Pembrokeshire County Council produced an information leaflet that was delivered as a mailshot to every household in the county. The mailshot was a bilingual communication providing information relating to community hubs for assistance with food/medicines, anti-social behaviour and safeguarding services. The Panel acknowledge this approach as good practice as it offered a way to ensure that every household received an information leaflet.

4.129 Whilst recognising this approach as good practice, it is the view of the Panel that the messaging and language used was very corporate in its style and content. Members of the public wouldn't necessarily relate to safeguarding language and it is the Panel's view that this an area for learning for any future information leaflets targeted at the public.

4.130 The Panel accepts that that the pandemic has required messaging of a nature and intensity not experienced in a lifetime for many people and that messages and communications intended for whole populations may never reach everyone. It is the Panel's view however that there are lessons to be learnt at both a national and regional level from the drive to digitalise information and services and the risks of excluding people who cannot or are unable to access these means of communication. The Panel also agreed with the recommendation made by the Older People's Commissioner that Public Bodies should take action to

[34] https://www.olderpeoplewales.com/Libraries/Uploads/Leave_no-one_behind_-_Action_for_an_age-friendly_recovery.sflb.ashx

ensure that public health messaging is communicated more effectively to older people, delivering clearer messaging in a more accessible way.

Suitability and Location of Housing

4.131 Health records provide 31 different addresses for June and Peter in England and Wales. The nature of short term stays in accommodation and moving between areas provided little opportunity for June to make friends or integrate in a community. The IMR provided by Hywel Dda University Health Board documents the challenges the couple had with accommodation and living environments. There are letters sent to the GP practice in 1995 asking for support in relation to housing issues and stating that Peter couldn't live in cities or too near to people.

4.132 In 2006, a further letter of support was provided by the GP practice supporting June and Peter's housing application on the basis of the stress and insomnia caused by noisy neighbours.

4.133 The letters follow a pattern in relation to use of capital letters and sections underlined that are seen in other examples of letters written by Peter and it is therefore presumed that the letters to the GPs detailed above were written by Peter and signed by both himself and June.

4.134 In 2003, when the couple registered with a GP Practice in Carmarthenshire, the registration form asked a number of social and well-being questions as well as those relating to medical history. June ticked that she was worried about other family members and that there were housing/accommodation problems. Peter ticked the boxes for depression, worries about other family members, employment change / unemployment, recent retirement and housing or accommodation problems. He added a further note to the questionnaire that they had moved there on medical grounds. There is no evidence in the medical records that any follow conversations took place to explore the matters raised in the questionnaire.

4.135 June and Peter first rent the cottage in 2009 and remain there until 2012 before returning in May 2013. They remained tenants there until June's death in February 2021.

4.136 The cottage is in an extremely isolated location. Access to the property is through a gate positioned near to the main road and a track of about 400 metres that leads only to the property. The property is not visible from the road and there are no neighbours. The only property within sight of the cottage is that of the landlord's parents. The Chair describes the location as remote and desolate and the landscape surrounding the cottage as exposed, hilly farmland. During bad weather, the cottage would have been inaccessible due to its exposure to the elements and distance from the main road.

4.137 The cottage itself is a single storey stone cottage. The property consists of a kitchen, bathroom, two bedrooms and a mezzanine floor above the living space. There is evidence that June slept in the larger of the bedrooms whilst Peter slept

in the small bedroom. There was a fuel burner in the main living area and electric storage heaters in the property.

4.138 On entering the cottage after June's death the landlord described the cottage as *cold and feeling very damp with black mould growing on the walls.* He was unsure how often the heating was being used and was aware of the fire being used only occasionally as he could see the smoke from his neighbouring property.

4.139 Whilst June and Peter lived at the property 2009 – 2012 and return in 2013 the hospital records following Peter's fall at the property in January 2017 indicate that Peter is unhappy at the property. The Doctor at Emergency Department notes that Peter receives Housing Benefit and that there is inadequate heating in the house. The Doctor advises Peter to speak to the council re adequacy of heating and to take his flu vaccine. It is good practice that the Doctor has recognised and responded to these wider well-being issues.

4.140 There is no evidence that Peter contacted Pembrokeshire County Council to discuss this matter but phone records indicate that June and Peter subsequently made an application for a flat in 2018 (no further details established). Texts to Daughter 2 in October 2018 read;
Disappointed. Application collapsed. Lost fee. Costly flat hidden obligations. Huge deposit required bad insulation. Housing benefit would be 4 weeks in arrears. Reak tried xx

Both ok. Need rest after move attempt. Benefit rules not allow to ever assist, accept we must where we decide suitable.

4.141 There are no further references in any agency contacts with June and Peter relating to housing/accommodation until Peter indicates during the phone conversation with the Property Manager in February 2021 that he and June would likely want to leave the house before next winter as they were both getting older and wanted to be closer to family.

4.142 Similar comments are made to the Property Surveyor the day before June body is discovered. Peter comments on the disrepair of the house and tells the surveyor that they wouldn't be spending another winter there as it was damp and the cold wasn't good for their health. He further stated that mobile reception was poor, that there was no landline and that he wasn't going to incur the costs of a landline.

4.143 Examination of the phone records show that calls were made to the following accommodation providers on the 8th February 2021;

- Anchor Care Homes – lasted 15 minutes
- Wales and West Housing Association – lasted 5 minutes
- Belvoir (Real estate rental company in Christchurch, Dorset) – 21 seconds

4.144 These calls, all made within half an hour of each other indicate that initial enquiries were being made in relation to alternative accommodation but from the

letters written by Peter found in the cottage, the information gleaned as a result of these contacts clearly left him feeling extremely frustrated;

Letting agents can demand 6 months rent in advance and 5 weeks rent as deposit to applicants receiving housing benefit. (The) COTTAGE is no longer suitable for us. Plus removal costs + new beds etc

the letting agent in Christchurch who was once willing to accept us on housing benefit (BELVDIR) now says when you phone 'DO NOT PHONE – EMAILS ONLY PLEASE'

There is no indication that he contacted Pembrokeshire County Council to discuss alternative housing options but he does state in the letter *council boarded up for a YEAR.*

Daughter 2 states in antecedent statement that

I am cross that my parents who tried so hard to move had no outside help to assist in their prime years

4.145 The Panel noted that the availability of rental properties during the Pandemic was extremely challenging however, from the information available to the review these initial enquires on the 8th February 2021 were the only proactive enquiries/attempts since 2018.

4.146 Daughter 2 had never visited the property prior to attending after her parents' deaths. In the antecedent statement, she questions the suitability and appropriateness of the accommodation for her parents. This view has to be balanced by the choices Peter had and was continuing to make and what was driving his decision-making.

4.147 Whilst the application for a flat is made in 2018 it does not appear that Peter made any attempt to seek assistance or information in relation to moving from the cottage after this until the phone calls made to accommodation providers in the weeks leading up to June's death.

4.148 June and Peter received maximum Housing Benefit, they had funds in their bank account and a not insignificant amount of cash was found in the cottage following June's death. What Peter writes in his letters about the costs of moving e.g. removals and new beds doesn't necessarily reflect the reality of their financial situation.

4.149 Daughter 2 expresses anger, frustration and self-blame in her antecedent statement as it relates to her parents accommodation;

My parents were probably lonelier than we as their family ever realised and I believe living in cottage made illnesses much worse….. We as their family should have tried to help as it could have been a lifeline if they had some assistance to move. Someone to chat to the council and help with benefits as my dad never wanted to do something that wasn't correct

4.150 Based on the information known to the Panel about Peter and his relationship with his family it is the Panel's view that he is unlikely to have accepted any help from family even if they had offered.

4.151 It is the Panel's view that Peter and June's accommodation – it's condition, location and lack of modern amenities and technology increased the couple's feeling of isolation and dislocation and affected Peter's ability to access services for both himself and June as well as exacerbating his feelings of frustration and inadequacy. It further served to make their needs less visible to services during the covid period when services, to a large degree operated remotely. Clearly they were unhappy with their living situation, and felt that it was problematic and had an adverse effect on their physical and mental health. Peter made some efforts to find something different but became quickly frustrated with the steps that he would need to follow to find a solution. These attempts were compounded by what he saw as complex bureaucracy and technological difficulties.

Concluding Remarks

4.152 As illustrated above in the overview and analysis, this Review is, to a degree, liminal and one dimensional in that lines of inquiry are limited by a lack of a well-rounded view of June as a person, her voice and what she thought about particular incidents/occurrences as well as how the pattern of her life developed.

4.153 The sequence of events is dominated by Peter, his experiences of and responses to those events. His dealings with agencies is the dominant narrative. It is clear that June's well-being is entirely bound to Peter's increasing frustration, feelings of inadequacy and inability to navigate services as evidenced by the series of communications with family members and the agencies concerned.

4.154 It is the Panel's view that the impact of Covid, digitalisation of services and perceived lack of accessibility to services exacerbated June's isolation and loneliness and that the narrative created by Peter further contributed to the sadness she references in her diary.

SECTION FIVE – LESSONS TO BE LEARNT

1. The lessons to be learnt for this Review result from agency IMRs and discussions at Panel meetings.

2. Single Agency

Hywel Dda University Health Board

- There is no evidence if June was accompanied on GP visits or Emergency Department attendances
- The GP surgery is unable to confirm if they wrote to June inviting her to attend for her COVID 19 vaccine and there is no record of how she declined the vaccination
- GP practice should have noted and acted on the request in the letter dated October 2020 and signed by June and Peter for correspondence to be made via letter due to the poor reception at the cottage
- The Health Board needs to review Emergency Department documentation to ensure that whichever pathway patients experience, it can evidence routine enquiry about domestic abuse and safeguarding
- The Health Board needs to improve links with Primary Care to ensure comprehensive assurance of compliance with VAWDASV guidance and practice

Welsh Ambulance Service NHS Trust

Documentation provides limited information beyond the clinical considerations of the incident in January 2017 and indicates;

- No record of any discussion or views of June or Peter regarding their wellbeing goals, which may have provided opportunity to engage with relevant services and support them in achieving any identified goals
- No record of a routine or targeted enquiry with regards to domestic abuse for either June or Peter. This does not provide an understanding of events at that time and may present a missed opportunity to link with relevant agencies for support
- Learning opportunity of documentation being completed with full consideration of health, social wellbeing and safety considerations of our patients and service users.

Dyfed Powys Police

- The Family Liaison Officer assigned to this case had no prior involvement with Domestic Homicide Reviews and hadn't received any training or information relating to DHRs. Before the Chair's meeting with the Family Liaison Officer in May 2021 the family had not been provided with any information relating to the review. Whilst the Liaison Officer facilitated initial contact with family members it is the Chair's view that had the Liaison Officer had an awareness and understanding of the DHR process this would have resulted in the family being aware of the review process at an earlier point in the investigation. An

understanding of the statutory nature of the review may also have assisted the Liaison Officer in recognising the aims and purpose of the review.

- This is one of three DHRs that the Chair has undertaken in Pembrokeshire, and it is her view that there is an inconsistency in Dyfed Powys Police's approach to the sharing of information for the purpose of a review with current approaches dependant on individual officers rather than an agreed force-wide protocol.

3. Regional and National

- It is the Panel's view that there are lessons to be learnt at both a national and regional level from the drive to digitalise information and services. Whilst digitalisation works for many in society there is a need to recognise the challenges and barriers this can present to groups including but not exclusively older people and make efforts to maintain a range of communication methods to reach as many individuals within our communities as possible.

At the meeting in February 2022, Panel members identified a further area of learning relating to attendance at review panel meetings. Panel members felt that it should be made clear at the first meeting that members are expected to attend for the duration of meetings. This has been included as a recommendation for the Chair and also for the Regional Violence against Women, Domestic Abuse and Sexual Violence Partnership.

SECTION SIX - RECOMMENDATIONS

1. The recommendations have been agreed by the Review Panel and discussed with representatives of the relevant agencies.

2. Single Agency Recommendations

Hywel Dda University Health Board

- Lead VAWDASV and Safeguarding Practitioner to work with primary care to strengthen links with local specialist domestic abuse services
- Acute Services, supported by the Lead VAWDASV and Safeguarding Practitioner to review the documentation used in Emergency Departments to record routine enquiry
- The Corporate Safeguarding Team to recommend to the Strategic Safeguarding Working Group that Ask and Act becomes routine rather than targeted enquiry within Emergency Departments across Hywel Dda University Health Board
- Clinical leads for Acute, Community, Primary Care and Mental Health services, supported by the Lead VAWDASV and Safeguarding Practitioner to communicate expectations in relation to the importance and means of recording whether patients attend alone or are accompanied during presentations/consultations
- The Corporate Safeguarding Team to audit the embedding of the Hywel Dda University Health Board's Ask and Act Policy in practice and report to the Strategic Safeguarding Working Group
- Primary Care to improve compliance with Group 2 Ask and Act training and establish a mechanism for monitoring and reporting compliance
- Primary Care to provide assurance that GP Practices have embedded the Mid and West Wales Regional Pathfinder for GPs based on the Safelives GP Pathfinder guidance
- Primary Care to ensure that GPs, Dental Practices and other primary care providers have access to Live Fear Free Helpline resources to display in settings

Dyfed Powys Police

- All Family Liaison Officers to receive training in relation to Domestic Homicide Reviews to improve their understanding of the review process and to enable them to inform families at the appropriate time that a review will be undertaken
- Implementation of a force wide policy relating to the sharing of information for the purpose of DHRs to ensure a consistency of approach across the four Local Authority areas

Welsh Ambulance Service NHS Trust

- Learning from this IMR be shared within the organisation to support the understanding of
    - Expected practice as it relates to the health and social care considerations of all patients and service users and

  - The principles of Social Services and Wellbeing (Wales) Act 2014 and Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 within the Welsh Ambulance Service Trust
- The Safeguarding Team to audit the embedding of the WAST Ask and Act Policy in practice and report to the relevant Strategic Safeguarding Group

Pembrokeshire County Council

- Commission a service/services that can provide a bespoke, tailored service to respond to the needs of older people who are experiencing domestic abuse

3. Recommendations for the Regional VAWDASV Board

- Ensure that the needs of older people experiencing domestic abuse, in particular those living in rural areas are fully taken into account in the review of the regional Violence against Women, Domestic Abuse and Sexual Violence strategy
- Co-design an information campaign with older people that is aimed at increasing older people and the general publics' awareness and recognition of abuse and where/how to access information and support locally. This information should be made available in community settings accessed by older people e.g. GP surgeries, pharmacies, libraries, community centres and supermarkets
- Ensure that a bespoke training programme relating to older people and domestic abuse is available to practitioners as part of the Regional Safeguarding Board's workforce development programme
- To share learning from the implementation of IRIS in Carmarthenshire to shape the roll out across Mid and West Wales
- Pilot and evaluate a Health Based IDVA approach within Hywel Dda University Health Board
- To develop a briefing that can be shared with members of DHR Panels outlining role, responsibilities and expectations

4. Recommendation for the Chair

- As part of first meeting with Review Panels ensure that reference is made to panel members attending for the duration of the meetings as part of her expectations of the Panel

5. National Recommendations

- Quality Assurance tools used across Primary Care to be revised and updated to ensure they are consistent with the Intercollegiate documents for child and adult safeguarding and the VAWDASV National Training Framework
- Welsh Government to mandate the adoption of IRIS within GP settings across Wales and provide sufficient resource to support implementation
- Welsh Government to clarify expectations relating to the implementation of the National Training Framework and Ask and Act in Primary care services specifically those services which are independently contracted e.g. GP and Dental Practices

This Domestic Homicide provides further evidence of the need to expedite the following recommendations made by the Older People's Commissioner in Wales in her recent reports;

- Public bodies should take action to ensure public health messaging is communicated more effectively to Older People
- Bespoke, evidence-based training modules relating to older people's experiences of VAWDASV should be included in the VAWDASV National Training Framework to improve identification and practitioner/service responses across all relevant authorities and specialist VAWDASV providers.
- Organisations falling outside the remit of the National Training Framework should be encouraged by Welsh Government to include bespoke, evidence-based training on the experiences and needs of older people experiencing VAWDASV within their workforce development plans.
- Welsh Government should establish a national taskforce to develop a strategic and system wide approach to improving responses to older people in order to ensure that the experiences and needs of older people are taken fully into account in national strategy and policy, good practice is disseminated and that any guidance issued covers the specific needs of older people.