SAFER PEMBROKESHIRE

PEMBROKESHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

DEATH OF JUNE IN FEBRUARY 2021

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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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 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.

2.3 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 bannister of the mezzanine floor overlooking the living area.

2.4 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.

2.5 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.

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

2.7 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.

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

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

2.10 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.

2.11 The Overview Report, Executive Summary and Action Plan were 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. Contributors to the Review

3.1 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.

3.2 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	

3.3 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.

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

3.5 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.

3.6 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.

3.7 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.

3.8 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.

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

4. The Review Panel Members

4.1 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.

4.2 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.

4.3 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.

4.4 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.

4.5 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.

4.6 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 May 2022

4.7 The following representatives were 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)
Supt.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

5. Appointment of an independent Chair /Author

5.1 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'.

5.2 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.

5.3 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.

5.4 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.

5.5 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.

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

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

6. Terms of Reference

6.1 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.

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

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

6.4 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 2013to 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*

The IMR's 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.

7. Summary Chronology

7.1 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.

7.2 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.

7.3 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*	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*

	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	*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	Authorisation for COVID 19 vaccination

	Too much pain	
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*	

8. Key Issues arising from the Review

June and how she lived her life

8.1 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.

8.2 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 and having her four children.

8.3 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 after her marriage.

8.4 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.[1]

8.5 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.

8.6 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.*

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

8.8 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

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

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.

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

<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

8.10 It is the Panel's view that Peter created a version of reality as a way of exercising 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.

8.11 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.

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

8.13 It is the Panel's view that the patterns of behaviours, 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, potential financial abuse, 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 moved frequently no agency sees the pattern as whole and individual events are seen as isolated behaviours.

8.14 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 their view that it is reasonable to conclude that there was a pattern of behaviour which included coercive and controlling behaviour.

8.15 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.

8.16 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[2].

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

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

8.18 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 then 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.

8.19 Having developed and employed these coping mechanisms for decades and Peter's behaviours becoming normalised for her it is likely to have taken specialist intervention and an investment of time for June to have identified the behaviours as abusive.

8.20 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

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

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.

8.21 The Dentist 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 episodes of acute pain with the exception of June's fall in January 2021.

8.22 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.[3]

8.23 The Panel identified the following key components in improving the identification of older people who are experiencing domestic abuse

- Training
- Awareness Raising
- Early Intervention
- Ask Me and Community based responses
- Perpetrators
- Bespoke and specialist support for older people who are experiencing abuse

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

- 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 Tina?

8.24 In response to the Covid pandemic the world was operating in a way that was far removed from what Peter was comfortable with and one which he 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

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

over him. It is the Panel's view that the changes to everyday life enforced by Covid left Peter feeling out of both 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.

8.25 It is the Panel's view that Peter created a narrative and his own reality that wasn't reflective of actual 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 during the pandemic 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.

8.26 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 everyday life 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.

8.27 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.[4]

<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

8.28 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

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

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)[5], concludes that it is possible there were assumptions that people would know that health services were available to access during the pandemic.

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

Housing – Suitability and Location

8.30 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.

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

9. Concluding Remarks

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.

The sequence of events is dominated by Peter and his experience 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.

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.

10. Lessons to be Learned

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

10.2 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 the Liaison Officer having an awareness

and understanding of the DHR process 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.

10.3 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.

10.4 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.

11. Recommendations

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

11.2 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

11.3 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 public's 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

11.4 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

11.5 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.