SAFER PEMBROKESHIRE

PEMBROKESHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

REPORT INTO THE DEATH OF JUDITH IN DECEMBER 2020

Report produced by Rhian Bowen-Davies
Independent Chair and Author

September 2022

A note to Judith's friends and family

As a family we cannot come to terms with what has happened to Judith and we never will. Judith was well respected in the community with a wide circle of friends and she was such a gentle person.

Judith was a sister, an auntie and a dear friend to many. She will be missed very much by those who knew and loved her.

The Panel offers its sincere condolences to you all and wishes to acknowledge the integral contributions that you have made to the Review which have enabled us to really understand Judith as a person and how she lived her life. Your detailed accounts of the months leading up to Judith's death have provided the Panel with a unique insight that would otherwise have been missing.

The Panel recognises the indescribable gap that Judith's death has left and how this loss continues to be felt in your day to day lives.

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

Contents **Page number**

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 Judith, a resident of Pembrokeshire prior to her death in December 2020.

1.2 Having discussed the use of pseudonyms with the family they have requested that Judith be referred to by her name in the report as the review is about her, how she lived her life and how she was murdered by her son Dale. The family have further requested that Dale also be identified in the review as this information is publicly available and easily searchable due to the media coverage that followed Judith's death. The Panel respects the wishes of Judith's family and have used Judith and Dale's names throughout the review.

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 In February 2021 Judith was found deceased by Dyfed Powys Police Officers in the bedroom of her flat in a state of decomposition, with a plastic bag over her head, a cable tied around her neck and a large amount of blood in the room. She was 68 years of age.

2.2 Judith hadn't been seen alive since the beginning of December 2020 and whilst her body wasn't discovered until February 2021 it was accepted during criminal proceedings that based on the culmination of evidence, she was killed sometime in December 2020.

2.3 A post-mortem recorded the cause of Judith's death as blunt force trauma to the head caused by being struck repeatedly with a hammer, but due to the environment in which the body was found and its decomposition it was unable to determine a time or exact date for her death.

2.4 Following an investigation by Dyfed Powys Police, Judith's son Dale was arrested and subsequently charged with her murder. In August 2021, Dale pleaded guilty to the murder of his mother and in October 2021 was sentenced to life imprisonment and ordered to serve a minimum of 21 years and six months before he can apply for parole.

2.5 An inquest into Judith's death was opened by the Coroner for Pembrokeshire and Carmarthenshire on the 8th April 2021. The Coroner decided not to resume the inquest in light of the outcome of the criminal proceedings.

2.6 Dyfed Powys Police notified Pembrokeshire Community Safety Partnership of this case on the 9th March 2021.

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, Probation Service and Mid and West Wales Fire and Rescue Service whereby the decision was taken to conduct a Domestic Homicide Review.

2.8 During this meeting concerns were raised regarding the potential for a DHR to jeopardise the criminal justice process in line with the Disclosure and Criminal Procedure Principles set out in Section 9 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

2.9 Accordingly, partners were unanimous in their view that, in accordance with paragraph 90 a) of the Home Office guidance, the DHR should be pended until after the outcome of any criminal proceedings.

2.10 The Home Office were notified of the decision to conduct the Domestic Homicide Review and to pend the review subject to the outcome of the criminal proceedings on the 2nd April 2021.

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

2.12 Following the conclusion of criminal proceedings in October 2021, a further meeting of statutory partners was convened on the 8th November to appoint the Independent Chair of the Review.

2.13 The first meeting of the Review Panel took place on the 26th November 2021.

2.14 The Overview Report, Executive Summary and Action Plan was presented to the Pembrokeshire Community Safety Partnership on the 7th October 2022.

2.15 Judith's body was discovered in February 2021 in the same week that 'June', a 71 year old female was killed by her husband in Pembrokeshire. Rhian Bowen-Davies was also the Chair for the review into June's death which was submitted to the Home Office in March 2022. Whilst the circumstances of Judith and June's deaths are different, the Chair and the respective Panels have identified a number of lessons to be learnt and recommendations that are applicable to both reviews and these are detailed throughout this report.

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 a meeting in August 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 at a meeting on 7th October 2022.

3.6 Until it was approved for publication by the Home Office Quality Assurance Panel it was in its final draft stage and remained 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 and family members engaged with the review.

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.

3.9 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, Older People's Commissioner for Wales and the Domestic Abuse Commissioner for England and Wales.

3.10 Panel representatives unanimously agreed that any learning and recommendations identified during the Review would be actioned prior to the report being submitted to the Home Office Quality Assurance Panel.

3.11 Furthermore, it was agreed by the Safer Pembrokeshire Community Safety Partnership that in light of this being the third review into the death of an older female in Pembrokeshire in the last 5 years a regional multi-agency event will be held on completion of this review to share thematic learning and recommendations.

4. Demographics

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

4.2 Judith lived in Pembroke Dock, a town in Pembrokeshire and it was here in 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. 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 2021, Dyfed Powys Police recorded 10,359 incidents of domestic abuse, a 9% increase on recorded incidents in 2020.

4.8 During the period April 2021 – March 2022 329 cases were discussed in the MARAC meetings in the region, 11% of these were repeat referrals.

4.9 This is the fourth Domestic Homicide Review undertaken by Pembrokeshire Community Safety Partnership, the third involving a female over the age of 65 years of age and consideration has been given to the findings and recommendations of the previous reviews. There are another 4 Domestic Homicide Reviews ongoing in the Mid and West Wales region at the time of writing this report, 3 of these involve the deaths of older women highlighting the need for a greater focus and prioritisation of this group within the regional Violence against Women, Domestic Abuse and Sexual Violence Strategy.

5. Terms of Reference

5.1 Terms of Reference were drafted by the Chair following the Panel meeting in November 2021. The draft Terms of Reference were shared with family members in January 2022 both at a meeting and via email. The family were able to clarify dates included in the scope of the meeting and the revised Terms of Reference were agreed by the Panel at their meeting in March 2022.

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

Purpose of the Review

The purpose of a 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 the home, family and community of Judith, 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 the death of Judith;*
- *To identify and examine patterns of behaviours perpetrated by Dale against his mother Judith and other members of her wider family;*
- *To examine the actions/responses of relevant agencies, services and professionals to both Judith and her son Dale within the agreed timeline;*
- *To consider how older women who are experiencing domestic abuse from an adult child access information, services and support;*

- *To examine how friends and family of older people who are experiencing domestic abuse access information and support;*
- *To examine the impact of Covid 19, in particular lockdowns, both on an individual's ability to access information and support and agency responses during this period;*
- *To ensure that the family and friends of Judith 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.*

Key Lines of enquiry

- *To identify and examine patterns of behaviour and abuse perpetrated by Dale against his mother Judith and members of her wider family;*
- *To identify which agencies/organisations had involvement with Judith and her son Dale during the scope of this review with the understanding that information outside of this timeline will be included where it is relevant;*
- *To review agencies/organisations involvement during the agreed timeline and consider the appropriateness of responses and services provided to Judith and her son Dale;*
- *To review the extent to which agencies/professionals worked together when responding to the needs and circumstances of the subjects of this review and the effectiveness of these responses;*
- *To determine whether decisions and actions in this case comply with the policy and procedures of services, national guidance and legislation and how these may have changed since the period in question; ensuring that learning is considered in the "here and now";*
- *To consider how older women who are experiencing domestic abuse from an adult child access information, services and support;*
- *To consider the experiences of Judith's friends and family and examine where/how they could access information and support;*
- *To examine the impact of Covid-19 on the daily lives of Judith and her son Dale;*
- *To examine the impact of Covid 19 on an older person's ability to access information and support and agency responses during this time;*
- *To consider Judith's age, gender and health conditions as factors throughout the review;*

- *To consider whether, and to what extent Mental Health and/or Substance Misuse contributed to the circumstances leading to Judith's death.*

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	*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*
Dr. Catherine Burrell	*Associate Medical Director, Hywel Dda University Health Board (Representing Primary Care)*
Geraint Hughes	*Service Manager, Community Drug and Alcohol Team, Hywel Dda University Health Board*
Lynne Richards	*Corporate Partnerships Officer, Pembrokeshire County Council*
Nicola Brown	*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*
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 Individual Managements Reports

Individual Management Reports (IMRs) will be requested from the following organisations;

- *Dyfed Powys Police*
- *Age Cymru Dyfed*

- *Pembrokeshire County Council (to include Social Services and Housing)*
- *Hywel Dda University Health Board*
- *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*
- *Welsh Ambulance Service NHS Trust*
- *The Scouts Association*
- *Department of 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 Judith and her son Dale for the period 2016 to the date of the discover of her body on the 20th February 2021.

Organisations are requested to include information outside of this timeline in their chronologies and IMRs where this is considered relevant.

Parallel Reviews

An inquest was opened into Judith's death on the 8th April 2021 and suspended pending the outcome of the murder inquiry. The Coroner decided not to resume the inquest in light of the outcome of the criminal proceedings.

An investigation was carried out by the Independent Office for Police Conduct which was concluded in August 2021.

Timescale, Report Author and Final Report

- *It is our intention that this Review takes no longer than 6 months to complete from the 26th November 2021 (first Review Panel meeting).*
- *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 Home Office 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, Police and Crime Commissioner for Dyfed Powys.*
- *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 from Dyfed Powys Police for an initial briefing. The Chair requested a further briefing be provided for Panel members at their first meeting in November 2021, which was also provided by the Senior Investigating Officer.

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

6.3 The Chair contacted members of Judith's family in December 2021 and a number of her friends in January 2022, details of which are included in Section 7 below.

6.4 In February 2022, the Chair wrote to Dale in prison offering him an opportunity to participate in the review. A response was received the same month from the Offender Manager Unit at the Prison informing the Chair that Dale did not wish to participate in the review.

6.5 Requests for Individual Management Reviews (IMRs) and chronologies were made to agencies listed in paragraph 9.2 below following the first Panel meeting in November 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 February, April and August 2022 where collectively, challenges and requests for further information / clarification were made 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 Officers;
- Pembrokeshire County Council housing wardens;
- Judith's last employer and
- Dale's last employer.

6.8 The Chair accessed a range of information that formed part of the police investigation including witness statements, phone and bank records to build an understanding of the circumstances leading to Judith's death.

6.9 The Chair was also provided with copies of Judith's diaries for 2017 and 2021.

6.10 The Chair, who is also the author, prepared the draft report, which was discussed and agreed by Panel members at a meeting in August 2022. Family members were contacted in July 2022 and offered the opportunity to read the report and provide feedback. Family members were provided with a copy of the draft report a week before meeting with the Chair in August 2022. The family agreed the draft report subject to two amendments to Judith's employment history which were incorporated into the final draft. Family members also raised a query in relation to the Out of Hours GP service which the Chair sought clarification and amended in the final draft.

6.11 The draft overview report, executive summary and action plan was presented to the Safer Pembrokeshire Community Safety Partnership at their meeting on the 7th October 2022.

7. Involvement of Family and Friends

7.1 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 Judith's friends and 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 Officers and the Family Liaison Officer who had supported friends

and family members through the criminal investigation. The Chair also met with the Victim Support Homicide Support Worker who was supporting family members.

7.4 From these conversations the Chair established that Judith had been estranged from her sisters with there being no contact between them for a number of years prior to her murder. Whilst the involvement of Judith's sisters and niece was recognised as important to the review process, the role of Judith's friends was seen as integral at this early stage.

7.5 In December 2021, the Chair, supported by the Victim Support Homicide Support Worker wrote to Judith's three sisters and niece with information relating to the Review and the offer to participate.

7.6 The letter, which was sent via the Victim Support Officer:

- Offered the Chair's condolences;
- 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;
- Acknowledged the support being provided by Victim Support;
- 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.

7.7 Further to the letter, two of Judith's sisters and her niece wished to participate in the review and an initial meeting was arranged with the Chair in January 2022. Two further meetings took place in March and August 2022. Email contact was maintained with family members throughout the review providing updates after each meeting and offering an opportunity to raise any questions at Panel meetings.

7.8 Judith's family provided invaluable context in relation to Judith's life outside of the timeline of the review and her relationships with her first husband H1 (Dale's father) and her second husband, H2. They contributed key information in relation to Judith's relationship with Dale and Dale's relationships with wider family members.

7.9 Judith's niece was instrumental in facilitating contact with individuals who had been in relationships with Dale and their accounts contribute to a picture of his abusive patterns of behaviour.

7.10 Family members were offered the opportunity to meet with the Panel but were happy to liaise with the Chair throughout the process and did not feel that meeting the Panel was required.

7.11 Anonymisation of the report and use of pseudonyms were discussed with family members at the beginning of the DHR process and when the Chair was drafting the report. Family members were adamant in their view that they wished for Judith to be referred to by her name in the report and the Panel has respected their wishes.

7.12 As outlined in paragraph 6.10 family members were provided with a copy of the draft report and met with the Chair in August 2022. During this meeting the family expressed their sadness on reading information that they had previously been unaware of. They further stated that the report had brought together information that had enabled them to see the bigger picture as it related to Judith and Dale's relationships and his behaviours. The family agreed the draft report subject to two amendments to Judith's employment history which have been included in the final draft.

7.13 The Family Liaison Officer contacted H1, Judith's first husband and Dale's father to offer the opportunity to participate in the review. He chose not to participate and no further contact was made with him.

7.14 The Family Liaison Officer further supported the Chair to contact six of Judith's closest friends, all of whom agreed to meet with the Chair and participate in the review. The Chair met with Judith's friends online and in person and their contributions have been integral to building a picture of Judith as a person and how she lived her life. One friend had known her for almost 50 years, others had worked with Judith in Social Services and had remained friends for decades whilst others had known Judith more recently as neighbours and through the Church.

7.15 It was during meetings with friends that the Chair was able to see detailed notes/records kept by two of them around their concerns for Judith from December 2020 onwards. Other friends showed the Chair messages exchanged with Judith in the months leading up to her murder and one friend had kept detailed records of contact with Judith and letters exchanged for years which she allowed the Chair to read.

7.16 The contributions of Judith's friends and family are included in the chronology and are detailed further in the Overview and Analysis Section.

7.17 The contribution of Judith's friends to this review cannot be underestimated. They knew her best and their memories and recollections of her are integral to our understanding of her as a person and how she lived her life. Furthermore,

it was their persistence in raising concerns to Dyfed Powys Police that led to the discovery of her body in February 2021.

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

8.5 During the Review enquiries were made in relation to an incident reported to Dyfed Powys Police in 2001 involving Judith and Dale. These enquiries revealed that the Dyfed Powys Panel Representative had been the Detective Constable in charge of the case. This information was made known to the Panel and Superintendent Evans had a conversation with the Chair in relation to his suitability to continue as a Panel Member. It was agreed by the Panel that Superintendent Evans would continue as a Panel member.

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 November, February, April and August 2022 before the draft report, executive summary and action plan was

presented to the Pembrokeshire Community Safety Partnership in October 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	No information returned
Department of Work and Pensions	Age Cymru Dyfed	Scouts Association
Dyfed Powys Police	Carmarthenshire Domestic Abuse Services	Welsh Ambulance Service NHS Trust
Hywel Dda University Health Board which included primary and secondary care	Calan Domestic Violence Service	
Mid and West Wales Fire and Rescue Service	Dewis Choice – specialist service for older people experiencing domestic abuse	
Pembrokeshire County Council (including Social Services and Housing)	Hafan Cymru (provider of IDVA service)	
	Live Fear Free – Welsh Government funded National Helpline	
	Probation Service	
	Pobl – provider of IDVA service in Pembrokeshire	
	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 Scouts Association and Welsh Ambulance Service NHS Trust. No information was received from either of these organisations.

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

9.5 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.

9.6 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.

9.7 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.

9.8 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.

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

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 In November 2021, Safer Pembrokeshire Community Safety Partnership requested expressions of interest from suitable applicants to Chair this review.

Expressions of interest were assessed by a panel made up of representatives from statutory services and Rhian Bowen-Davies was appointed.

10.3 Rhian has a strong combination of practice, leadership and policy-based experience in the field of violence against women, domestic abuse and sexual violence. 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. She has recently been commissioned by the Partnership to review the existing strategy and develop a new strategy for 2023-2027.

10.5 This is the third Domestic Homicide Review that Rhian has chaired in Pembrokeshire and, as a result of this, a decision has been made by the Chair of the Community Safety Partnership that she will no longer be eligible to submit an expression of interest for any future reviews. This decision will enable a different Chair, with different experiences to undertake any future reviews.

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 (AAFDA) DHR Chair's training. She is also a member of the Domestic Homicide Review Chair's Network facilitated by AAFDA.

11. Parallel Reviews

11.1 An inquest was opened into Judith's death on the 8th April 2021 and suspended pending the outcome of the murder inquiry. The Coroner decided not to resume the inquest in light of the outcome of the criminal proceedings.

11.2 An investigation was carried out by the Independent Office for Police Conduct (IOPC) into the response of Dyfed Powys Police to concerns raised about Judith's welfare by friends and neighbours in January and February 2021. The investigation was concluded in August 2021 and the Chair and Panel had sight of the Investigation Report.

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. This section outlines the protected characteristics that were considered as significant factors by the Panel.

12.2 This is a case of Parricide – the killing of one's parent by a son or daughter and of Matricide – the killing of one's mother. This is often referred to as Adult Family Homicide. Research in these areas present further evidence to support the focus on the protected characteristics identified by the panel.

12.3 Studies consistently show that Adult Family Homicide is gendered[1],[2] with the most common form of Adult Family Homicide being parricide. Existing international research suggests that perpetrators are more likely to be the son or grandson of the victim who is usually female (Cussen and Bryant, 2015; Sharp-Jeffs and Kelly, 2016)[3].

12.4 A study by Bows[4] spanning 2010-2015 found that of the 221 cases of domestic homicides of older people in England and Wales 44% were the result of parricide and committed by a child or grandchild

12.5 Holt researched and published England and Wales' first national analysis of parricide in 2017[5].The research draws on data from the Home Office Homicide Index to examine all recorded cases of parricide over a 36-year period and examines the characteristics of offenders, victims, incidents and court outcomes.

12.6 The research identified 693 incidents of parricide between 1977 and 2012 – equating to around 19 each year. In 23 of those incidents, both parents were killed while the rest claimed the life of one parent.

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[1] Holt, A (2017) Parricide in England and Wales (1977-2012) An exploration of offenders, victims, incidents and outcomes Criminology and Crime Justice 17 (5) pp568-587

[2] Bows,H. and Davies,P.(2019) "Elder Homicide in the UK (2010-2015): A gendered examination'. In Bows, H. (Ed.) Violence against Older Women, Volume 1. Basingstoke: Palgrave Macmillan.

[3] Bracewell, K. and Jones, C. Haines-Delmont, A. Craig, E. Duxbury, J. Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide, *Journal of Gender-Based Violence*, vol XX, no XX, 1–16,

[4] Bows, H (2018 Domestic Homicide of Older People (2010-2015): A comparative analysis of intimate partner homicide and parricide cases in the UK

[5] Holt, A. (2017). Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents and outcomes. *Criminology and Criminal Justice*, *17*(5), 568-587

12.7 Findings of the research are summarised below;

- Around 90% of the perpetrators were male ranging in age from 11 to 69 and around 9% were juveniles (under 18)
- 51% of those killed were fathers and 49% were mothers with ages ranging from 25 to 101 years
- The most common methods of killing were using a blunt or sharp instrument (60%), strangulation (16%), kicking or hitting (10%), and shooting (7%). It is suggested in the study that that methods of killing in family homicides and the extensive pain and suffering produced by sharp or blunt objects suggest a presence of rage and an absence of care in cases of parricide.
- While men and women are equally likely to be the victims of parricide, this does not hold across the lifecycle: most men are killed by their offspring when in their 50s and most women are killed by their offspring when in their 70s. Thus, while the '70 years and over' age-range is generally considered to be a 'low-risk' age range for overall homicide victimisation (constituting only 8% of all homicide victims) (ONS, 2014), it is certainly not 'low-risk' for matricide victimisation: 37% of female victims were 70 years or over compared with 29% of male victims, which is a significant association.

12.8 Analysis by Bows (2019)[6] confirms the findings of Holt (2017) that older women are at a higher risk of being a victim of parricide than older men.

12.9 Whilst theories of parricide have been dominated by the 'typology of parricide' which focuses on perpetrator psychopathology, Holt[7] advocates away from this and towards exploring continuums of violence within the family shaped by wider factors such as substance misuse, financial issues, criminal history and living with the victim.

12.10 An analysis of 66 adult family Domestic Homicide Reviews[8] published between 2012 and 2018 identified five interlinked themes as key factors in the perpetration of adult familial homicides; mental health and substance misuse, a history of criminal behaviour, childhood trauma, financial issues and dynamics of care.

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[6] Bows, Hannah (2019) '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). pp. 1234-1253.

[7] Holt, A (2017) Parricide in England and Wales (1977-2012): An exploration of offenders, victims, incidents and outcomes. Criminology and Criminal Justice.

[8] Cussen and Bryant, 2015, Sharp-Jeffs and Kelly 2016 as referenced in Bracewell, K. and Jones, C. Haines-Delmont, A. Craig, E. Duxbury, J. Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide, *Journal of Gender-Based Violence*, vol XX, no XX, 1–16,

12.11 Age, sex, disability and sexual orientation are considered as factors throughout the review and examined within the report. Some of the evidence as to why we are considering these protected characteristics is listed below:

Sex:

- 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).
- 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).
- 110 women were killed by men in 2020. Of these cases 13% killed by son, 15% were killed with blunt instrument and 45% cases would be described as overkill – defined as excessive or gratuitous violence beyond that necessary to cause the victims death[9]

Age:

Judith was 68 years old at the time of her murder.

- 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.[10]
- 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

[9] https://www.femicidecensus.org/reports/
[10] Violence against Older Women End of Project Report, Dr. Hannah Bows, Durham University April 2020

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[11],[12].
- The majority of domestic homicide victims are female (67%) and perpetrators are male (81%).[13] Older people are almost equally as likely to be killed by a partner/spouse (46%) as they are their (adult) children or grandchildren (44%).
- Of the cases examined for the Older Victims Spotlight Briefing[14] overall Adult Family Homicide deaths involved an even split by sex of the victim (male and female victims each representing 50%). However, when examining Adult Family Homicides of older victims the proportion of female victims increased to a level similar to that of Intimate Partner Homicide.
- In the same Spotlight Briefing it was highlighted that of the Adult Family Homicide deaths involving older victims, 71% (12 cases) of victims were a parent and 29% a grandparent.
- Adult Family Homicide demonstrates an older victim profile than Intimate Partner Homicide (43% of Adult Family Homicide victims and 18% of Intimate Partner Homicide were 65 years or older). This is consistently supported by previous research (Bows and Davies, 2019, Holt, 2017 and Montique, 2019)[15]
- Analysis by the Vulnerability, Knowledge and Practice Programme suggests that during the first year of the pandemic, the proportion of older victims of Adult Family Homicide increased from 35% to 43%.[16]
- In November 2020, the Femicide Census published an overview of femicides that had occurred between 2009 and 2018. Of the 1425 women

[11] 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.
[12] 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
[13] 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.
[14] 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

[15] Vulnerability Knowledge and Practice Programme, Domestic Homicides and Suspected Victim Suicides During the Covid 19 Pandemic 2020-21 Lis Bates, Katharine Hoegar, Melanie-Jane Stoneman and Angela Whitaker
[16] 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

murdered 278 were over the age of 60 years of age and 127 of these had experienced extreme violence[17].

- A SafeLives Report published in 2016[18] 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[19] 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'[20] 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.[21] 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 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.

[17] https://www.femicidecensus.org/reports/
[18] Safe Later Lives; Older People and Domestic Abuse; safe Lives October 2016
[19] http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf
[20] http://www.safelives.org.uk/practice_blog/what-domestic-homicide-reviews-tell-us-about-abuse-older-people
[21] London Domestic Homicide Case Analysis and review of Local Authority DHR processes October 2019 Bear Montique

- 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.[22] 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.
- 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[23].
  - 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.[24] 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 compared to reports in urban areas.[25] 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

[22] https://olderpeople.wales/resource-category/reports/
[23] 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)
[24] Welsh Women's Aid Briefing: Rurality and VAWDASV
[25] 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

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.

Disability:

12.12 Judith suffered with respiratory conditions through her adult life including Chronic Obstructive Pulmonary Disease (COPD) and asthma, both of which restricted her mobility resulting in her using a mobility scooter. Judith also had diagnoses of osteoarthritis, ulcerative colitis and hypothyroidism.

12.13 The Equality Act (2010) defines a disability as:

A physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal activities. 'Substantial' is more than minor or trivial, for example, it takes much longer than it usually would to complete a daily task like getting dressed. A 'long-term' effect is one which has lasted at least 12 months; or where the total period for which it lasts is likely to be at least 12 months; or which is likely to last for the rest of your life. If the effects are sometimes absent or less severe, they are treated as continuing if they are likely to recur. This means that people with fluctuating conditions such as depression, arthritis or asthma can be covered.

12.14 More than 11 million people live with a limiting long-term illness, impairment or disability in the UK. This is almost one in five people and the proportion increases with age. Around 6% of children are affected compared to 16% of working age adults and 45% of adults over state pension age.[26]

12.15 Disabled people experience higher rates of domestic abuse than non- disabled people. In the year to March 2015 the Crime Survey for England and Wales reported that women and men with a long-standing illness or disability were more than twice as likely to experience some form of domestic abuse than women and men with no long-standing illness or disability.[27]

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[26] Department for Work & Pensions, Office for Disabilities. Statistics: Disability facts and figures. Department for Work & Pensions, Office for Disabilities, 2014

[27] Crime Survey for England and Wales 2015. In the year to March 2015 the Crime Survey reported women (16%) and men (8.8%) with a long standing illness or disability were more likely to experience some form of domestic abuse than women (6.8%) and men (3.2%) with no long standing illness or disability

12.16 SafeLives' data reveals that disabled victims typically endure abuse for an average of 3.3 years before accessing support, compared to 2.3 years for non-disabled victims. [28]

12.17 Disabled people more likely to experience domestic abuse, they also experience domestic abuse that is more severe, more frequent and lasts for longer periods.[29] [30] [31]

12.18 Data for England and Wales[32] also suggests that the severity of impairment increases the risk of violence: people with limiting disabilities have significantly higher rates of domestic abuse, stalking and violence compared to people with non-limiting disabilities and no disabilities[33] [34] [35].People with a:

- non-limiting disability are 1.6 times more likely to experience violence than people with no disability
- limiting disability are 2.3 times more likely to experience violence than people with no disability
- non-limiting disability are 1.77 times more likely to experience domestic abuse in the past year than people with no disability
- limiting disability are two times more likely to experience domestic abuse in the past year than people with no disability
- non-limiting disability are 1.54 times more likely to experience stalking in the past year than people with no disability
- limiting disability are 2.1 times more likely to experience stalking in the past year than people with no disability[28,35]

[28]https://safelives.org.uk/sites/default/files/resources/Disabled%20Survivors%20Too%20CORRECTED.pdf

[29] Adding insult to injury: intimate partner violence among women and men reporting activity limitations. Cohen, M. et al. 8, 2006, Annals of Epidemiology, Vol. 16, pp. 644-651.

[30] Prevalence of abuse of women with physical disabilities. Young, M. et al. 1997, Archives of Physical Medicine and Rehabilitation, Vol. 78, pp. 34-38.

[31] Partner violence against women with disabilities: prevalence, risk and explanations. Brownridge, D. 2006, Violence against women, Vol. 12, pp. 805-822.

[32] Disability and Domestic Abuse Risk, Impact and Response Public Health England 2015 Colleen Dockerty, Dr Justin Varney, Rachel Jay-Webster

[33] Flatley, J., et al. Crime in England and Wales 2009/2010: Findings from the British Crime Survey and police recorded crime. London : Home Office, 2010.

[34] Smith, K., Colemand, K., Eder, S. & Hall, P. Homicides, Firearm Offences and Intimate Violence 2009/10: Supplementary Volume 2 to Crime in England and Wales. Home Office, 2011.

[35] Home Office. 2009-10 British Crime Survey Questionnaire. 2009

Sexual Orientation

12.19 Dale identifies as gay and his sexual orientation was known to family and was discussed by Judith with her friends. Family and friends were of the view that whilst Judith accepted Dale's sexual orientation, Dale's father, H1, who was 12 years older than Judith and had served in the Army struggled to accept this.

12.20 Dale's sexual orientation is considered in relation to a number of key lines of enquiry examined in this report.

12.21 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.

SECTION TWO – SUBJECTS OF THE REVIEW

In addition to Judith and Dale the following persons are referred to in this report;

F1	Friend and neighbour of Judith
F2	Friend of Judith's for over 50 years
F3	Friend and former colleague of Judith
F4	Friend and neighbour of Judith
F5	Friend and former colleague of Judith
P1	Dale's ex-partner
P2	Dale's ex-partner
H1	Judith's first husband and Dale's father
H2	Judith's second husband

Judith

The Panel are humbled to have had such a detailed insight into Judith as a person and how she lived her life not only from her friends and family but also her own voice from diary entries.

Judith was a White, British Woman who was 68 years old at the time of her murder in December 2020.

Judith suffered with respiratory conditions through her adult life including Chronic Obstructive Pulmonary Disease (COPD) and asthma, both of which restricted her mobility. Judith also had diagnoses of osteoarthritis, ulcerative colitis and hypothyroidism.

Judith was prescribed regular medication, one of which was a controlled drug Gabapentin.

Judith was born in Pembrokeshire and lived in the county for most of her life.

Judith was one of 4 biological sisters however a female cousin was also considered a sister and is referred to as such in this review. One of Judith's biological sisters died in 2013. At the time of her murder Judith and her sisters had not spoken for 7 years. Judith maintained contact with her niece until 2018 but had not spoken with her for a number of years prior to her murder.

In 1972, Judith married H1, twelve years her senior and in the Army. In 1977 she gave birth to their son, Dale. Judith and H1 separated in 1998 and divorced in 2000.

Following the separation from H1, Judith moved from the family home and purchased a bungalow is a nearby village.

Dale was in his final year of University at the time of his parents' separation and on returning home continued to live with H1 in what had been the family home. H1 remains at the property to this date.

As a young woman, Judith worked in a local chemist on the cosmetics counter and as a dental nurse before starting employment with Social Services as a Carer. Having successfully completed qualifications, Judith became an Assistant Social Worker, working with adults in hospital. Her manager and another colleague in Social Services describe her as *always looking to better herself….very capable…. always wanted to learn and ambitious for herself.*

Her colleagues recall how debilitating her respiratory conditions were, especially in the cold weather when she would experience difficulties in breathing. It was due to her ill-health that Judith had to finish work with Social Services.

In 2003, Judith met H2 whom she married and moved to Cyprus to live in 2007.

Friends and family describe Judith as being very happy in Cyprus. Judith reported that the warmer climate had benefits for her health, and she spent her time singing in pubs and clubs, something which she loved.

Judith returned to Pembrokeshire in 2013 alone and her divorce from H2 was finalised in November 2018.

Friends and family members state that the relationship with H2 ended due to his misuse of alcohol and his spending of their money, including Judith's savings. They recall Judith *being distraught* on her return to Pembrokeshire as she came home with no money and very few belongings.

On returning to Pembrokeshire Judith lived in a private rented flat before moving to Local Authority sheltered accommodation in 2014. The property, which was her home until her death was a one-bedroom ground floor flat, one of four in a block and was located on a street with other local authority sheltered accommodation and privately owned houses. Judith's flat had gardens at the front and rear and was next to a house whose owner Judith became friendly with, F1. As designated sheltered accommodation, there was a Local Authority warden for the property who had regular contact with Judith.

Due to her financial situation Judith had to return to work when she came back from Cyprus and was employed as night staff at a care home between 2013 and 2015.

The manager of the care home remembers Judith as a *lovely lady, friendly and easy to get along* with who was happy to cover additional shifts at the home when required. Judith left the role due to her health conditions and did not work again.

Judith was in receipt of State Pension, Employment Pension and Personal Independence Payment, a monthly income of £1082.

Friends and family members all describe Judith as *immaculate.* They spoke about the perfect colour coordination of her clothes, make up and jewellery and how she

never left the house without her make up. Judith kept a note in her diary of when her hair had been coloured and her nails painted.

They describe her as being *very precise, everything had its place and a place for everything.*

Her homes had always been a sense of pride for Judith and friends and family remember how immaculate the marital home and her bungalow had been. One friend stated that *it hurt her that it (the flat) was a Local Authority flat – she had always owned her homes.*

The warden for Judith's flat describes it as *sparsely furnished but very clean and tidy.*

Friends describe how Judith worked hard to make the flat her own including borrowing a drill from F1 to do DIY. She planned meticulously for improvements which can be seen in the list of jobs she kept in her diary. In 2020, she details the new fence that Dale put up in the garden for her dog Ruby, the new flooring she has fitted and the decorating of the living room much of which she does herself. F1 described how she was invited around to see the finished living room and how Judith was thrilled with the result.

Judith was a woman who liked routine and promptness. This was consistently referred to by those who knew her but is also evident in her diary entries. Her morning routine consisted of breakfast, dressing, make-up and any house chores needed on that day. She kept a note of when she washed her bedding and detailed any cleaning that she had done that day. Friends were unanimous in that she was never late for anything.

Prior to Covid her weekly routine included choir practice, church and visits to the local social club over the weekend.

A friend describes Judith as having *a beautiful soprano voice* and she would regularly sing solo during choir performances. All of her friends said how much she loved singing and how music had always been a part of her life.

Judith was a very creative person, with friends remembering how she would spend her time cross-stitching, knitting and making jewellery. During Covid she began to make moulded garden ornaments, some of which she had in her own garden but often she would give what she made to friends and neighbours as gifts for Christmas or birthdays, all of which she detailed in her diary.

Friends spoke about Judith's keen sense of humour and how much fun she was to spend time with. Judith thrived when she was with people and loved entertaining with her singing, music and playing the guitar.

She also liked to shock people, having had a number of tattoos and piercings in her 50's and 60's.

Friends spoke of her kind and caring nature, knitting clothes for their grandchildren and being there at times of crisis in their lives.

Judith was a Christian and is described by the Vicar as a *having a strong faith and being a valued member of our church, she belonged, she was one of us*.

All Judith's friends spoke about Ruby, Judith's dog who had been with her since 2020 and who she adored. They describe Ruby as Judith's *companion*. Ruby gave Judith a reason to go walking every day and even when Judith's health deteriorated and she needed to use her mobility scooter people would see her out with Ruby, Judith on the scooter and Ruby alongside her on the lead. Ruby would go to doggy day care every week something which Judith would detail in her diary.

Friends were also honest about how Judith could be *outspoken, stubborn and bloody minded.* They spoke about Judith being quite rigid in her views and straight with people, *please or offend she would tell you as she saw it…..nothing was couched.* From her diary entries it can be seen how this honesty had, at times, cost her friendships. One friend said that she felt Judith got a *sense of status from her feistiness* whilst others felt that this was a front to a fragility in her that she tried to hide from everyone*.*

A number of her friends spoke about how they felt status was important to Judith, both in terms of appearance and social setting. They felt that this was important to Judith as far back as her marriage to H1, him being in the Army, having a lovely home and the perception that they had a *perfect life.*

Judith was an independent, determined woman who, at times could offend with her opinions and forthrightness but a person who is also described as talented, fun, kind and caring. Having spoken to those who knew her best it is clear that she will be missed dearly.

Dale

Dale is a White, British male who was 42 years of age at the time he killed his mother. Judith's neighbours and friends describe him as physically large and Dale's last employer referred to him as *physically intimidating*.

Dale is gay, a fact that was known to family and friends since Dale was a teenager. Whilst Dale's sexual orientation was accepted by Judith and she told friends she had known that Dale was gay from a young age, friends and family were of the view that H1 struggled to accept his son's sexual orientation.

Dale was Judith and H1's only child and family say that he was spoilt and indulged both as a child and an adult, being given everything he wanted. As a child they describe him as *sly and not sociable or affectionate.*

Judith's family describe him as *Jekyll and Hyde – funny, intelligent and the life and soul of the party one minute but with a nasty streak.* They also describe him as *intimidating.* One of Judith's friends describes Dale as *cold.*

Family recall Dale threatening his grandmother (Judith's mother) with a knife as a teenager, after which she was frightened and was never on her own with him.

Friends and family were unsure how the separation and divorce of his parents affected Dale. He was in his final year of University at the time of the separation and returned to Pembrokeshire shortly afterwards, without completing his degree, to live with his father.

Dale had a tenancy in a Local Authority property for 2 months in 2016 during which a notice was served for abandonment. It is understood that he returned to live with H1 before moving in with Judith in October 2020. In his statement to Dyfed Powys Police H1 stated that he was *glad of a rest from Dale as he wasn't easy to live with.* Some of the reasons for this statement are explored below.

F2 who had known Judith for over 50 years and was also Dale's godmother was always worried that Dale would try to come between her and Judith. When she didn't receive replies to her text messages over Christmas 2020, she was worried that Dale had said something to come between them.

Dale reports chronic back pain to GP in 2014 and was prescribed controlled drugs including opiate, benzodiazepine and pregabalin.

He was diagnosed with herniated lumbar discs and underwent surgery in November 2018. He continued to require medication to manage pain following this surgery.

Dale's last employment was as a residential support worker for young people where he was employed between July 2019 and April 2020. He was described as unreliable by his manager who further stated that Dale would often have an excuse to leave early. The manager confirmed that Dale was furloughed for a very brief period in April 2020 due to the pandemic.

Dale's contract was ended following a report by a female member of staff that Dale had behaved in an aggressive way towards her, swearing and using inappropriate language. The female member of staff had locked herself in a room because she was frightened of him.

When the manager had addressed this with Dale he describes Dale as *holding himself very tight, he became very snappy and denied what had happened.*

The manager described Dale as clever. He'd convinced his father that he still worked there as H1 rang and spoke to the Manager about 6 months after Dale's contract had ended believing he was still working there.

The Panel also noted that Dale volunteered at the local Scout Group holding numerous positions from January 2013 until February 2021 following his arrest and being charged with Judith's murder.

During the course of the Review, Judith's niece made contact with two of Dale's former partners on behalf of the Chair. The Chair provides some questions which Judith's niece asked and shared the responses with the Chair.

P1 described how he had been in a relationship with Dale for 5 years and how the relationship had been *verbally aggressive and emotionally draining.* He described Dale as *untrustworthy and a compulsive liar*. He further stated that Dale had been heavily involved with recreational drugs (speed) and how this had a negative impact on their relationship.

P2 described Dale as very charismatic and fun to be around but that the relationship was abusive.

Everyone liked him. He was so good at pretending to be the life and soul of the party and people got totally sucked in before realising he was laughing at them.

He described how Dale had systematically isolated him from friends and how he would lie continuously during the relationship

He was sneaky but so plausible……He would lie about everything, get found out and retreat whilst his web collapsed. Emerge a while later. New friends, different lies.

He recalled how money was an issue for Dale, Dale controlled the money in the relationship, and they were evicted from a property because Dale hadn't been paying the rent.

Dale would regularly use cannabis and P2 states that without the cannabis Dale *wasn't a nice person – he would be pacing, slamming doors and being aggressive*.

After leaving the relationship and moving away Dale persuaded P2 to return to Pembrokeshire and resume the relationship. Dale's behaviours did not change and P2 confronted him before ending the relationship. P2 said the following about Dale

Every time his web of deceit collapsed he spiralled out of control.

SECTION THREE – CHRONOLOGY

1.1 The combined chronology below sets out relevant key events, contacts and involvement with Judith and Dale by agencies, professionals and friends who have contributed to the review. It also includes entries made by Judith in her diaries in 2017 and 2020 and information gathered in the course of the police investigation.

1.2 The Terms of Reference set out the scope of the review from 2016 to the date that Judith's body was discovered 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 context that has been considered as part of the review.

1.3 Entries in the chronology relating to Dale are in italics for ease of reference.

18/06/2001	Judith reports that cheques/postal orders had been taken from a room within her house and cashed at a local Post Office. Dale is arrested at his home and upon searching his room stubs from the stolen postal orders are found. Judith did not wish to support a prosecution and Dale received an Adult caution for the offences of theft from dwelling and obtaining property by deception x 3.
14/02/2011	Dale was admitted to hospital following an intentional overdose of insulin. This was reported to have been his aunt's medical treatment. At the time of the admission Dale was reported to have said that he wanted to die and not wake up. He stated he had experienced a stressful year and had recently split with his partner of 4 and half years. He described how he was living with his aunt at the time, and his mother was living in Cyprus. Once Dale's medical needs were stabilised, he was assessed by the Crisis Intervention Team from Mental Health services. His aunt and mother were present during this assessment, (his mother had flown back from Cyprus). They offered to leave Dale alone with the Crisis Team Worker, but he indicated that they both could remain present during the discussion. Dale reported financial problems, with work being temperamental and some 'friends turning their back on him'. He had decided to go to Cyprus and had given up his property, which he felt had been a mistake and he could not bring himself to tell his mother. He felt that the only way out of this was to take an overdose. He also described how this was an impulsive act, due to an accumulation of worries, including a relationship breakdown with his father, and some issues about being homosexual. He realised that this was a mistake, he now wanted to live, and reported plans for the future. He described loving his job, (his occupation is not recorded within these records). He was provided with the number for Pembrokeshire Counselling Services, and his mother agreed to take him to the Citizens Advice Bureau to receive advice about his financial concerns. He was advised to contact the GP if feeling low, or if he needed a referral to the Community Mental Health services. He also agreed to contact being made, to provide him with a free phone helpline to access in the future if he was feeling distressed or was not coping. He was subsequently discharged from the Mental Health service and discharged from the medical ward on the 15/02/2011.
10/11/2014	Judith's tenancy started
29/04/2015	Judith self refers to Social Services Occupational Therapy. The referral states that she has mobility difficulties due to severe breathing problems and intends getting a disability scooter. However, outside her warden-controlled property there are several steps and she is asking for a ramp to enable her to get the scooter in and out of the property. It is noted that Judith lives in a ground floor council flat.

	Adapted bathroom, has pull cord for emergencies. Has had to wait to be back in country for 2 years before applying for PIP. She lived in Cyprus for 6 years due to health reasons.
30/04/2015	Judith is spoken to in relation to her referral. She advises that she is applying for PIP and has not yet bought a scooter. She is advised that if she had Blue Badge and PIP enhanced mobility supplement - DLA Mobility equivalent and letter of intent to buy from scooter supplier, she could go directly to grants. Alternatively could go on waiting list for OT assessment. Judith states that she will investigate the benefits but would like to go on the Occupational Therapy waiting list.
09/07/2015	County Councillor contacts Social Services on Judith's behalf requesting a new path for level access to the front of her property, also needed is a scooter store shed for her mobility scooter. This contact is referred to the Grants Department for assessment/advice
10/07/2015	Social Services note that Judith is already on the Occupational Therapy waiting list and awaiting allocation following the contact from the Councillor on 9/7
03/09/2015	Occupational Therapy visit to Judith's flat. Records note Judith suffers with chronic respiratory conditions, she can be very short of breath on exertion and sometimes too unwell to leave her property. Her condition is expected to deteriorate further in the future, making her more reliant on mobility aids to get about. When she is well enough she goes outdoors using a mobility scooter to gain access to shops etc. Judith lives in a block of sheltered flats and would therefore require a communal ramp to provide level access from her front door to the pavement. Both her and her neighbour both have scooters and are aware that they do not currently meet the criteria for scooter storage. There is concern however that they will continue to store the scooters on the planned pathway, which may not be wide enough for the other to pass. The neighbour also currently parks in front of Judith's property. Recommendation sent to Grants for the identified requirements - no other needs identified.
30/10/2015	*Dale applies to join Pembrokeshire Housing register. Home address recorded as Dad's address. Application processed and bidding number awarded*
29/01/2016	Home visit by GP – complaining of sciatica. Commenced on Oramorph.
10/02/2016	Telephone call with GP – medication requested. Awaiting results of MRI.
12/02/2016	Result of MRI scan to the lumbar and sacral spine received by the GP and GP contacts Judith to discuss
15/02/2016	*Dale is offered a tenancy with Pembrokeshire County Council*
17/02/2016	Notification of Judith attending preoperative assessment clinic sent to the GP. Unable to proceed with operation due to thyroid level and referred back to the GP to review thyroxine medication dosage

19/02/2016	Ramped access to Judith's property completed
22/02/2016	*Dale starts his tenancy with Pembrokeshire County Council*
13/06/2016	DWP letter sent to Judith confirming that PIP payment would continue at standard rate of mobility
14/04/2016	*7 day notice for abandonment served on Dale*
24/04/2016	*Pembrokeshire County Council regain possession of the property and Dale's tenancy ended.*
14/06/2016	*Dale contacts GP surgery. GP notes* *History of being retrieved from the ship he was working on due to flare up of back pain. Left his medication on board in that confusion. Vessel will be back in 2 weeks.* *GP issues not fit for work statement for 2 weeks.* *GP advises Dale to come into surgery if worse.* *Noted on the record that patient is asked to be careful with his medication otherwise may be tempted to put him on weekly script.*
29/06/2016	*Review appointment with the GP. Dale requesting Morphine sulphate tablet now back in the UK. Discussed Benzodiazepine usage and longer term potential consequences. Dale amenable to slow reduction. Morphine tablets prescribed. Reduce Oramorph quantity receiving. 2 weeks supply given to gauge effect. Noted in the record – opioid type drug dependency.*
23/08/2016	Judith has a bunionectomy on her right foot and is discharged home.
08/09/2016	*Dale requests medication from the GP. Record notes that he says he is due to work away from now to 20th October- has enough medication to last until the end of September, requesting extra 20 days, looking at notes and drug history it appears he has requested medication twice in August, and he says he has left medication whilst out in Rotterdam. Discussed with colleagues he should have 12 days supply extra as he said he would retrieve the medication he left in Rotterdam.* *1 week medication given but noted that GP discusses that they cannot keep reissuing controlled and addictive medication.*
17/10/2016	*Dale requests more medication from GP stating that he has been using more oramorph and has run out of them. GP issues an increase from 20mg to 30mg twice a day. GP records* *Note made for no further opioids to be issued until the 15/11/16. Patient says he works abroad. ? drug dependency, please monitor*
23/11/2016	*Dale requests further medication - 2mg tablets of diazepam for 'lunchtime pain'* *GP declines further increase and directs fortnightly scripts. GP advises Dale that he needs to evidence that he is going away, as pattern of travel doesn't fit with previous time stated away.*

	GP offers forward dated prescriptions. Dale states that she is changing jobs so will be easier to pick these up.
01/12/2016	Judith is diagnosed with ulcerative colitis
19/12/2016	*Dale is assessed by the Chronic Pain Service.* *Assessment included a self-completed questionnaire on pain management. Dale is assessed by physiotherapist from the pain management team.* *Dale reports he has constant pain in lower back, and is currently addicted to diazepam, but GP in process of controlled reduction. Used cannabis and amphetamines during early 20's. Assessment made my physiotherapist records;- Chronic lower back pain, addicted to diazepam, low mood, needs support. For CMAT referral. ? Pain management team at a later date.* *Discharged from Pain management.* *Referral made to Clinical Musculoskeletal Assessment and Treatment Service (CMATS)*
31/12/2016	Judith diary entry A disappointing end to the year. Huge argument with Dale re not paying back loans and telling lies. He's 39 – time to grow up. He paid money to me eventually but quite horrible to me on the phone telling me I had never supported him or defended him. Really hurtful. Why don't I have a family anymore? He told me he was that close to not bothering with me anymore. He must please himself, No more loans, No more sitting waiting for visits. No more making arrangements to go out for him to let me down. Please God let me be strong enough to stick to the above, to live my life as my own with what friends I have.
24/01/2017	*Letter from Judith scanned onto Dale's notes.* *Letter addressed to Dale's GP. Judith describes concerns related to Dale's mental health, and fabrication of employment and educational attainment. Also relayed concerns about his behaviour, including eating issues and stealing from his family. Dale had reportedly told his mother that he is due to see a psychologist following his referral to pain management clinic. Judith* *reports that she has discussed these concerns with Dale and he has agreed to get help from GP. However, he is not aware of this letter being sent.*
10/02/2017	*Letter sent to GP following appointment at Chronic Pain Management clinic. Letter states that Dale has been reviewed at the clinic and seen by a specialist physiotherapist assessor. Dale reported that he is managing pain with medication. Letter states that Dale is to be referred to Primary Mental Health*

	Team as described feeling 'increasingly isolated'. Describes how pain impacts on ability to physically function, mood and disturbed sleep patterns. Also referred to the Clinical Musculoskeletal Assessment and Treatment Team. Notes also reference that he has supportive parents nearby.
21/02/2017	Judith complains of episode of absences – seen by GP on the same day, tests ordered and referral sent to medical physician
01/03/2017	Judith completes a form for Pembrokeshire County Council Housing on which she states that they are not to give the key safe number to her son.
02/03/2017	*Dale states that he is going away to work and requests medication. GP records state* *One week supply given. Will discuss diazepam usage when returns from work. Still wary of how much patient is requesting*
15/03/2017	Judith attends medical review with the GP. Blood results discussed and no further vacant episodes reported. Awaiting further tests – CT scan of head and referral to TIA clinic.
22/03/2017	Judith contacts GP Practice asking for an emergency appointment as she has fallen and hurt her thumb. She is advised to attend Emergency Department. GP receives a notification of attendance at the Emergency Department on the 22/3/2017. She reports that she has fallen onto an outstretched hand. Treatment given and for review in outpatients. Seen in outpatients fracture clinic – no bony injury and discharged to GP.
07/04/2017	*Dale attends appointment with the Community Musculoskeletal Assessment and Treatment Service. Reviewed by an Advanced Physiotherapist Practitioner. Dale complaining of back pain and bilateral leg pain and would like to consider surgery. Referral made to neighbouring Health Board, Spinal Unit.*
15/08/2017	Report from CT scan of head – scan shows small vessel disease. Noted for review in medical clinic.
23/09/2017	*Dale attends Out of Hours Doctors Service to request medication. Script given for Pregabalin and advised to contact his own GP. Notification sent to GP.*
28/09/2017	*Dale contacts GP Practice requesting medication for 2 weeks as going away. Dale states that he is using 20mls of Oramorph a day but GP notes that he appears to be using more than this. Dale is advised that no further script will be given as he already has a prescription.*
07/10/2017	*Dale seen by Out of Hours Service requesting Pregabalin medication – medication issued and notification of contact sent to GP.*
09/10/2017	*Dale attends a review at the Surgery. He requests diazepam and increase in Pregabalin. GP not happy to increase medication but prescribes 1 tablet of diazepam.* *A note by GP on the record which states – Using a lot of interim scripts ? overusing – speak to DR (colleague)*

23/10/2017	*Administration note on Dale's GP record stating – multiple requests for prescriptions, running out early. Consider increased frequency of pick up.* *Scripts changed to daily pick up and appointment made for Dale to see GP in 2 weeks.*
26/10/2017	Prompt received from HMRC regarding an increase in contributions (paid via customers working life) that had been identified resulting in a higher amount of State Pension being awarded. Arrears of £733.36 paid to Judith.
28/10/2017	*Dale attends Out of Hours Service requesting pain relief. Prescription given and notification sent to the GP. It is noted that this is the third request to Out of Hours in six weeks.*
08/11/2017	Judith Diary entry Dale had found my Gabapentin and taken them.
11/11/2017	*Dale attends Out of Hours Service requesting pain relief.* *Noted on GP record that further information received from pharmacy following consultation- noted that 'Dale was economical with the truth' already on daily scripts.* *Special note on system that not to be prescribed MST or Pregabalin by Out of hours service.*
21/11/2017	*Dale contacts GP requesting more Oramorph. GP increases frequency of collection of medication for Dale to daily collection and discusses Dale with colleague.*
12/12/2017	Judith attends Ear Nose and Throat Clinic – to undergo a further biopsy.
16/01/2018	*GP reviews medication with Dale. Dale asks for relaxation of daily scripts as inconvenient.* *GP agreed to go to twice weekly and advises Dale that should he lose any scripts or if there are any issues then will go back to daily.*
16/01/2018	Judith attends ENT clinic for the septal biopsy. No sinister findings and discharged from clinic.
05/02/2018	GP received notification that Judith has undergone foot surgery to remove screws from her toe. Discharged from orthopaedic clinic.
21/03/2018	Both Judith and the warden for Judith's housing called Police to report that Judith had found a vodka bottle with burnt paper in her garden. A Police Community Support Officer (PCSO) spoke to Judith and made Pembroke Neighbourhood Policing Team aware to conduct patrols in the area in respect of potential local Anti-Social behaviour.
26/04/2018	*Medication Review for Dale. He requests weekly pick ups for medication. Based on the fact there have been no issues for 5 months the GP agrees and changes the scripts to weekly collection.*

05/10/2018	Judith attends Emergency Department with a shoulder injury – reports falling into a wall 5-7 days ago. X-ray taken. No bony injury and discharged.
17/10/2018	*DWP records – Fit note received from Dale 16/10/18 – 18/12/2018 condition listed herniated lumbar discs. Universal credit claim processed.*
13/11/2018	*Discharge letter from Hospital – Dale underwent primary decompression surgery on his spine. Follow up scheduled for 6 weeks.*
08/01/2019	*Fit note recorded 20/12/2018 to 31/01/2019 by DWP for Dale*
05/02/2019	Judith reported hearing an alarm coming from a neighbour's flat. Police attended and attempted to locate the key to the property. A neighbour had left something on their stove. Neighbour was treated by ambulance for smoke inhalation.
12/02/2019	*Dale did not attend his follow up appointment with neurosurgeon. Dale was offered opportunity to contact consultant's secretary rearrange an alternative follow up appointment .*
16/02/2019	Judith calls 101, concerned that a neighbour's electric scooter is blocking steps and could cause a fire as it is continually on electric charging. Judith explains that this issue is effecting her mental health and that she was 'worried sick, cant stop thinking that this charger will blow I'm very emotional" Call handler notes that the "caller was very teary on the line". Police spoke to both parties no offences disclosed. No further Police action required. Judith stated that she had rung Housing about the issue prior to Police but was told to ring back on the following Monday.
06/03/2019	Judith applies to join Pembrokeshire County Council Housing Register to transfer from her flat. The application is processed and a bidding number awarded.
07/03/2019	Home Fire Safety Check carried out by Mid and West Wales Fire Service at Judith's flat. Smoke alarm checked and fire safety assessment completed.
13/03/2019	*Dale is referred for a Work Capability Assessment.*
25/03/2019	Pembrokeshire County Council receive a letter outlining issues with neighbours which are affecting her mental health. A medium medical award – silver band noted on her application.
09/05/2020	Judith Diary entry Dale arrived – wanting Gabapentin.
15/05/2019	Judith calls Pembrokeshire County Council Social services to make a self-referral for an Occupational Therapy assessment for a scooter store. Records state that Judith has asthma and COPD and has problems with her feet. Customer said at present she is walking ok but that can change daily some

	days, so relies on her scooter. Has had foot surgery which did not resolve. In recipe of low-rate PIP and no blue badge.
20/05/2019	Pembrokeshire County Council Area Housing Warden completes a support plan with Judith which states • *Further assistance – referral made for a gable end gate for the puppy* • *Safe and Secure – Judith feels safe and secure* • *Finances – all ok* • *Social and leisure – All good she has a 5 month old puppy now* • *Mobility – Mobility has improved and she need to use her scooter so much now (sic)* • *Care and Support – All ok – Support plan updated*
29/05/2019	Occupational Therapy assessment takes place at Judith's flat and a referral made to Grants for a scooter store.
03/06/2019	Judith calls Pembrokeshire County Council via the Contact Centre asking for her application for a transfer to be closed down, as she needed a scooter store and wanted to remain where she is.
10/06/2019	Mid and West Wales Fire and Rescue Service complete a Home Fire Safety Check at Judith's property. Smoke alarm checked and an electric blanket provided. A home safety risk assessment completed.
08/08/2019	Judith attends Hospital for cataract surgery. Nursing care assessment completed with Judith - preoperative review. Judith is asked the following questions to which negative responses are recorded for each. • Are there concerns regarding significant others while the patient attends hospital? • Is there a concern that there may be an adult/child at risk? (Consider if there are an adult at risk of abuse or neglect, consider domestic abuse) • Does the patient express concerns for their safety? Surgery is completed and Judith discharged to GP.
16/09/2019	*Phone call documented in Dale's GP records* *Phone call from Pharmacy. Scripts have been altered to receive medication earlier presented on the weekend, medication was issued on 14/9/19 (Saturday).*

	Pharmacy wishing to check if this had been completed by a GP in the surgery. Scripts faxed to the surgery who confirmed signature was not recognised as any of the doctors in the practice.
24/09/2019	*Pharmacist contacts GP concerned that Dale is without medication, trying to buy codeine medication from them. GP advises Pharmacist to tell Dale to make an appointment.* *They discuss the altered scripts from the previous week and GP advises Pharmacist that they need to contact the police.*
25/09/2019	*Dale has an appointment with GP and admits that he has lost control of his medication. Back to daily script.*
17/10/2019	Judith attends pre-admission appointment for planned foot surgery. As part of the Nursing record assessment Judith is asked the following Routine Enquiry Domestic Abuse questions - Does anyone at home physically hurt you? Does anyone else in your home insult, talk down or try to control you? Do you ever feel threatened in your current relationship? Does your partner/ ex-partner or anyone else at home shout, swear at you so that you feel unsafe? Negative responses to all questions.
07/11/2019	*Dale attends medical appointment. It's noted that he's doing well on daily medication and feels back in control. Agree to move to twice weekly medication.*
18/12/2019	Extension letter issued for PIP – extended the award until 2025 before light touch review.
21/01/2020	*Dyfed Powys Police respond to a call made by Dale who is working as a support worker in a residential home for young people. Dale is the support worker of a victim of an assault.*
06/02/2020	Post-operative assessment undertaken by physiotherapy department. Judith reports being anxious about going home and states that her son will support. A request for support at home completed to assist Judith with washing, dressing and making snacks.
07/02/2020	Home visit by care staff. It is noted that Dale is there to support Judith and a further visit scheduled for the next day.
08/02/2020	Home visit by care staff. Dale answers the door. Some assistance given with activities of daily living. Further visit planned for the following day.
09/02/2020	Home care staff visit. Judith had already been able to get herself washed and dressed prior to staff attending. Care staff discussed care needs with Judith who stated that she does not require further support and that her son is taking care of her. No further support planned.
20/03/2020	Judith contacts DWP to inform them of a change in marital status from married to divorced as of 30/11/2018. Status is updated on DWP records.

21/05/2020	*Dale reports to GP that he has been good for 6 months but worse the last two weeks due to a fall. Agreed to try alternative Non-steroidal anti-inflammatory medication (NSAIDS). Dale is advised to call back if no improvement in 2-4 weeks.*
23/05/2020	Judith Diary entry Big argument with Dale as he has found key box and taken gabapentamin (sic). Really cross – he must have been searching in drawers etc for keys. Feel violated.
24/06/2020	Phone call from Judith to F3. F3 makes notes of the phone call afterwards which read Phone call from Judith. My son needs help. He doesn't know the difference between fantasy and reality. Been here today telling stories. Tells stories that are not true. Dale said that he can't help it. Judith wanting to help him – we should go and talk to someone about this. Judith wanting him to go to the GP, offered to go with him but he refused. Judith said to F3 – what do you do? Man twice my size, how do I take him to an appointment? Judith was so upset on the phone.
10/08/2020	Visit to Home Address by Area Warden 2, Pembrokeshire County Council Housing. Record states *Met son outside property, did not meet Judith. No issues reported by Son.*
12/08/2020	Telephone call from Area Warden 1 Pembrokeshire County Council Housing All ok, no issues to report from Judith
26/08/2020	Warden 2 conducts a home visit and records All well, no issues reported spoke to the son unsure whether Judith was present
02/09/2020	*Medical review with GP. Dale states that he is struggling on Wednesdays. Improvement in the last week. Found Naproxen helpful. Has been getting out and about walking. Dale requesting Oramorph – hoping not to need it for long. GP prescribes medication.*
19/09/2020	*Universal Credit payments re-start to Dale*
October 2020	F3 recalls that sometime in October Judith rings her and says 'You won't believe it – Dale paid me back £200' (no record of this in Judith's Diary where she lists payments made and received from Dale).
03/10/2020	F3 speaks to Judith who tells her she's been in a terrible state with asthma – hasn't been able to breathe properly for 4 days but is getting over it

05/10/2020	Telephone call from Warden 1 All ok no problems to report from Judith.
08/10/2020	F2 meets Judith for lunch – this is the last time she sees her.
17/10/2020	Judith attends Emergency Department following a fall at home. Judith stated that she had been climbing on the toilet to reach for a bottle of bleach, lost balance and fell to the floor. She has struggled to walk to door to open it for Paramedics. Patient concerned about transport home as does not have any money. Noted prior to discharge – felt 'disturbed talking about discharge, living home alone'. Safeguarding questions asked- Are there any concerns about- adults or children at risk, domestic abuse, violence against women, or sexual violence. Negative responses to all safeguarding questions. Transport home arranged via the Red Cross. Discharged home with diazepam medication.
19/10/2020	*Dale's Universal Credit payment stops due to earnings*
20/10/2020	Phone call with F3 Judith tells her that she's been in hospital after her fall.
26/10/2020	Telephone consultation between GP and Judith. Judith requesting more analgesia for back pain following a fall in October. Asking for diazepam and Oramorph. Doctor advises that she can have one or the other and Judith requests Oramorph. GP arranges for prescription to be sent to the Pharmacy.
26/10/2020	Warden 2 telephone call with Judith Spoken about extending household – son is looking after her
02/11/2020	Telephone consultation between Judith and GP. Judith complaining of spasms in back as result of previous fall. Judith is advised to stay active and is issued with Baclofen and Oramorph.
09/11/2020	Warden 2 completes a home visit (does not recall seeing Judith on this visit) *Son answered the door, he says she hasn't been well and he does most of the household chores. Updated daily living skills section of the support plan.*
19/11/2020	Judith has a virtual appointment with Orthopaedic consultant. She reports doing well following surgery and is discharged from the service.
19/11/2020	*Dale's Universal Credit payment re-started*
20/11/2020	Judith Diary entry

	I discovered my Gabapentamin (sic) box only had 1 card not 6. Really told Dale off. I need those tablets. I checked app – money missing from both accounts. Rang H1 – he said that Dale was at work today. Didn't know he was on furlough. Just what I thought. Car? Knew nothing about it. Told him about tablets and money. Said he's also having probs. Dale came in and I told him T and I are going to speak to each other so don't play us off against each other. Went through app, £150 gone from savings and £142.95 from Debit. Rang Dale – admitted it. Said he'd repay me Monday. I really feel betrayed. Dale has obviously gone through drawers looking for tablets and has abused my trust with debit card when I couldn't walk. Also had taken savings card out of purse. Don't know how he had PIN must have looked in contacts. Message to/from F2. Glad I'd spoken to H1 – said we should continue.
20/11/2020	Facebook message from Judith to F2 Dale arrived home while I was talking to H1 which is good. I want to stay in touch with T. Did suggest that and he said yes…but there was one huge story. I just can't get my head around it. Tonight I feel I want to take my key off him, cut ties but he's my only family.
23/11/2020	Judith Diary entry Tried to ask Dale about lies etc. Said he can't talk about it. Told him I want my money back this week.
24/11/2020	Judith Diary entry Dale arrived. Said I won't be having my script.
25/11/2020	Judith Diary entry Rang Dale said I'd be furious if I walk to chemist and there's no script. …Dale turned up after 2pm said I can't have more tabs.
26/11/2020	Judith Diary entry Dale asked could he listen to audio book on my phone – NO! Can access too much.
29/11/2020	Facebook message from Judith to F2 to say sorry to have bothered her last week (20th)

30/11/2020	Judith Diary entry No money today. Will go to town tomorrow – he will get money. I can put into acc (we'll see). I am paranoid, constantly checking purse and phone bank app.
02/12/2020	Judith's last diary entry Tabs be ready after 2 today. He's going to town this morning (money?) and be over this pm….Txt from Dale – script won't be there – put my tabs on his name! 2nd text later – money sorted.
02/12/2020	Warden 1 attempts to call Judith – no reply
09/12/2020	*Medical Review with GP Dale reports feeling loss of control and requests daily scripts. All medication moved to daily scripts.*
14/12/2020	Warden 2 completes a Home Visit *Asthma but otherwise well.* *Warden 2 thinks he saw Judith on this day as no mention of son in the case notes however all that is recorded is that above.
21/12/2020	*Dale messages P1* *How for art thee? Home and hound sitting for mother. I can pretty much ignore everything. Got nicely dmt'd for my bday*
23/12/2020	Last direct debit for rent top up received by Pembrokeshire County Council from Judith's account
23/12/2020	Warden 1 *Leaflet drop. Whilst delivering in top block son advised his mum had gone to stay with family*
25/12/2020	F2 messages Judith 'Merry Christmas' – delivered but not read.
25/12/2020	*Complainant calls 999 to report a male outside her house. Describes male as possibly under influence, crawling around may have damaged her light and ringing her bell. He tells caller through letterbox his name is Dale and lives locally. Caller stated that she did not wish to make a complaint only to make sure the male was safe.* *Police attend and speak to Dale and confirm he is intoxicated, had fallen over and injured himself. Male taken to home address. Drunk male confirmed as Dale.*

	Caller did not wish to make a complaint of criminal damage. General crime prevention advice issued to caller.
27/12/2020	F2 messages "Judith, are you alright?'
30/12/2020	F2 received message from Dale Belated Merry Christmas, Mum unwell and had to call an ambulance. Wouldn't take her in due to covid. Mum will ring when new phone arrives.'
30/12/2020	*Note from Pharmacy received by the GP – Dale reporting loss of control and requesting daily scripts (already in place).*
08/01/2021	Warden 2 attempts to call Judith – no reply.
09/01/2021	*Messages exchanged with P1* *P1 asks him how he is and how was Christmas. Dale responds* '*Tats good. Healthwise anyway. Glad to know this. I'm ok. Same old same old except on crutches. Dislocated over Christmas. Really convenient.* *Just inconvenient really. Walking the hound is the interesting part.'*
11/01/2021	Warden 2 attempts to call Judith – no reply.
13/01/2021	Warden 1 sends text messages to Judith *Hi Judith, hope that you are ok.* Reply received from Judith's phone *Hi. Very chesty but being looked after* Warden 1 responds *Good to hear that you are ok Happy New Year.*
23 and 24 January 2021	F3 rings Judith and the phone isn't working. F3 asks a friend to text Judith but friend doesn't receive a response.

	F3 contacts F4 and explains that she has been trying to contact Judith. F4 agrees to go to Judith's flat. The front door is opened by Dale who states that his mum was in Hospital 1 and had been for 2 weeks. Dale gave F4 his phone number. He further stated that they wouldn't discharge her because her oxygen levels were not high enough. Dale stated that Judith had fallen and broken her phone and that was the reason that there was no answer on her phone. F3 rings Dale and is told the same.
24/01/2021	Concerned F1 called 101 to report not physically seeing Judith since the beginning of December. Reveals conversations with and about Dale. F1 does not know Dale's surname or telephone number but that he lives in locally. F1 states that Dale had told her just after Christmas that Judith had "gone to a friends' house for a few weeks to help her as her husband was dying". F1 then tells Police call handler that she had however heard from doggy day care that they had been told by Dale that Judith was in Hospital 2. Hospitals checked carried out by Dyfed Powys Police Ops room. Call allocated to local officer who then phones H1 (ex-husband, Dale's father). H1 confirms to the officer that his son Dale is living with his mother at the her address and had been since 22/1/21. The same officer then phones the address and speaks with Dale who said he was at home with Judith self-isolating. The Officer then phones F1 to update her and Dale makes himself known to F1 (at her window) as the officer is speaking with her. No further action police report.
26/01/2021	F2 receives a voicemail from Dale to say that Judith in hospital. F2 rang Dale – no reply. Dale rang back to say that Judith had been taken to Hospital 3 as she was having difficulties breathing.
31/01/2021	F2 texts Dale to ask how Judith was. He replied that there's been an improvement over the last few days, she is on oxygen and has started physio to strengthen lungs and muscles. She was heading in the right direction.
31/01/2021	Dale tells F3 that Judith is in Hospital 4
01/2/2021	Warden 1 visits the block of flats to tests the communal alarm.

	Warden 1 tests the alarm but then has difficulty locking the communal door and running the numbers on the key safe to place the keys back in there. Dale comes out from Judith's flat to the communal entrance door and watches Warden 1 trying to lock the key safe. He said he would do it. Warden 1 asked how Judith was and he said she was in Hospital 4 with Asthma issues. Warden 1 left the property and Dale indicated to them that he had locked the safe. It is noted that the key safe referenced in this entry is the communal key safe and not the key safe to Judith's property referenced in the March 2017 entry.
07/02/2021	Dale tells F3 that Judith is off the oxygen and will be discharged on Tuesday
08/02/2021	F2 sends a message to Dale asking how his mum was Dale messaged to say that Judith was improving and that she'd possibly be home at the end of the week. Will know more by the 11th and will let her know. F2 tells him to look after himself.
08/02/2021	Warden 1 attends at the property again to test the alarm. It's noted on the system that Judith is still in Hospital. Warden 1 recalls possibly speaking with Dale who came to the communal door in his dressing gown.
13/02/2021	Dale texts F2 to say that Judith expected home on Monday. Should have been yesterday but Pembrokeshire County Council needed to put support in for Judith before she came home
14/02/2021	Dale contacts F3 to say that Judith's return home had been delayed until next Tuesday due to the support package
18/01/2021	F3 rings Judith to say hello as she was expecting her to have been discharged on the 16th. Phone not working so made contact with old colleagues from Social Services to ask if they had heard from Judith. F3 makes enquiries with her old colleague as to who the carers are. Colleagues checked with community care team and they stated that they had not heard of Judith.
19/02/2021	F3 phones Hospital 4 to ask what time Judith is being discharged. No record of Judith at the hospital. Concerned F3 calls Dyfed Powys Police concerned for welfare of Judith. After discussing her concerns, it was agreed F3 would speak to Dale and recontact Police if she was still concerned.

	F3 speaks to Dale who states that he is expecting Judith home around 6pm. F3 speaks to Dale at 6pm and he states that Judith is not expected home until 8.30/9pm. She states that she will ring back at 9.30pm. She rings at 9.30pm and Dale's phone is switched off. Left a message. F3 leaves another message left at 21.36
20/02/2021	F3 rings and leaves a messages for Dale at 14.20.
20/02/2021	Concerned F3 calls Dyfed Powys Police out of concern for Judith. Informs Police that Dale is lying to her about Judith's whereabouts stating she was in Hospital but when she rang there they said she wasn't there and no other friends/neighbours have seen her. Police attend at Judith's home and see her body through the curtains in the rear bedroom.
24/02/2021	Adult Safeguarding Team, Pembrokeshire Social Services received Multi Agency Referral Form, The Scout Association. Subject (Dale) has been arrested for the murder of his mother. Adult Safeguarding Strategy discussion. However, it was identified that Dale was a person working with children and not adults at risk. Children's Social Care Team were informed, who later received a MARF from Police on 26/02/21. Ascertained that Dale a member of the Scouts Organisation holding numerous positions from 11/01/13 until that time.
26/02/2021	Strategy meeting convened – Social Services and Dyfed Powys Police. Agreed that a Section 5 Professionals meeting to be convened with all relevant agencies to be invited.
08/03/2021	Initial and outcome Section 5 Strategy meeting held in respect of Dale.

SECTION FOUR – OVERVIEW AND ANALYSIS

This section examines the events and contacts detailed in the chronology to provide an overview, consider the Key Lines of Enquiry and to identify good practice, learning and recommendations. It is structured as set out below:

1. Adult Familial Abuse: Understanding the Backgrounds and Patterns of Perpetrator Behaviour

Overview

1.1 In order to understand the nature of adult familial abuse and how it applies to Judith and Dale's relationship this section examines some of the underlying factors and key features identified in relevant research.

1.2 A study undertaken by Bracewell et al[36] highlights five features of adult family homicides which provides further context to and frames the patterns of behaviour and abuse under consideration. They are:

- Mental health and substance misuse. The report found that mental health was a dominant feature with 53% of perpetrators reported to have diagnosed mental health problems most frequently psychotic disorders and mood disorders such as depression. A common risk factor amongst perpetrators was substance misuse featuring for over 60%. Several DHRs reported mental health and substance misuse comorbidity especially amongst perpetrators.
- Criminal Behaviour. The study found that over 70% of perpetrators had a history of criminal behaviour.
- Childhood Trauma. Adverse childhood experiences are traumatic events, particularly those in early childhood that significantly affect the health and well-being of people. These experiences range from suffering verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present[37]. Perpetrators childhoods were included in half of DHRs examined by the study.
- Financial Issues. Where employment was listed in the reviews analysed, 72% of perpetrators were unemployed. In almost a third of the cases the victim was retired.
- Dynamics of Care. In the reviews analysed more than half of the victims had physical health problems. The study acknowledges that while this may be linked to the older age range of victims of familial homicide it is also a

[36] Bracewell, K. and Jones, C. Haines-Delmont, A. Craig, E. Duxbury, J. Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide, *Journal of Gender-Based Violence*

[37] https://phw.nhs.wales/topics/adverse-childhood-experiences/

vulnerability factor which can increase the need for formal/informal care or reliance on relatives. The study further identified that the 'carer', usually the perpetrator appeared to have substantial care, mental health or substance misuse issues themselves and often stole from the victim or subjected them to sexual or physical abuse.

Analysis

1.3 Dale's profile and patterns of behaviour has commonality with the themes listed above.

Mental Health and Substance Misuse

1.4 See paragraphs 11.12.-11.20 for a detailed analysis of this key line of enquiry.

Criminal Behaviour

1.5 Dale only received an Adult Caution for the incident reported by Judith in 2001 and wasn't subject to any other complaints to police by Judith. However, his pattern of criminal behaviours can be seen from a teenager in his relationships with Judith, wider family members and ex-partners with incidents including repeated thefts of money and medication, controlling behaviours and threats with a knife towards his grandmother.

Childhood Trauma

1.6 Family members' account of Dale was that he was spoilt, both as an adult and as a child and was given everything he wanted. This can be seen from Judith's diary entries where she notes what Dale has asked for his birthday and Christmas and then buys him these items in addition to other gifts.

1.7 Family and friends spoke about Judith and H1's separation which happened when Dale was in his final year of university. Whilst Dale returned to live with his father, he maintained a relationship with Judith but it is unclear to what extent the separation and subsequent divorce may have impacted on him. It was suggested by one friend that Dale held Judith responsible for his parent's separation.

1.8 When considering Judith's diary entries at the end of 2016 she writes that Dale *blames his childhood NO* and this may be referring to his belief that she had been responsible for the separation and subsequent divorce. It is the Panel's view that this perception may also have contributed to the rage that P2 describes Dale as having against Judith.

1.9 Friends and family also spoke about the pressure and sense of expectation Dale may have felt from his parents in terms of university and career. Judith spoke to her friends about not being allowed to go to college as a young

women and how she wanted these opportunities for Dale. It is the Panel's view that Dale's failure to complete his degree and secure any long-term employment would have been a sense of disappointment to his parents and knowing this, Dale perpetuated a reality for himself based on lies which Judith repeatedly discovered.

Financial Issues

1.10 Dale claimed Universal Credit between January 2018 and December 2019 as he was unable to work due to the pain in his back. He then started to work in the care home for young people until he lost this job in April 2020 due to his behaviours. He claimed Universal Credit again from September 2020 until the time he was arrested in February 2021. It is clear that maintaining an income was problematic for Dale and that he wanted more money than he had available to him.

1.11 Friends were aware that Judith would 'lend' Dale money and would then struggle to get this back from him, at times unable to buy food or do things she enjoyed as she didn't have the money to do so. When F3 is told that Judith is in hospital she is concerned that Dale will have access to her accounts and will be stealing from her.

1.12 His ex-partner describes how Dale controlled the finances in the relationship but didn't pay the rent or bills and Judith told friends she didn't know what Dale did with money. Friends and family were aware that he stole money from them and Judith.

1.13 It is clear that economic abuse was a significant factor in Judith's relationship with Dale and, as outlined elsewhere in the report, were potentially a key contributor to her murder.

1.14 Prior to her fall in October 2020, Dale would ask Judith to borrow money however, whilst she was unwell he stole money from her accounts using the banking apps on her phone which he continues to do after killing her, indicating a sense of entitlement.

Dynamics of Care

1.15 It is the Panel's view that Dale subjected Judith to a repeated pattern of economic abuse, manipulation and control. He controls Judith through economic abuse, lies and manipulation all of which are evident from friends, family and Judith's own accounts. His power and control in the relationship can be seen through his pattern of making plans with Judith only to let her down knowing how disappointed she will be. He uses the fact that he is her only family to his full advantage especially during lockdown periods. His power and control further increase when Judith is vulnerable, stealing her money and medication when she is unwell and dependent on him.

1.16 It is the view of the panel that the change from borrowing to blatant theft in this period (when Dale moves into Judith's home) marks a significant step change and an accelerated sense of entitlement from Dale's perspective. It changes the dynamic of the relationship and marks an escalation in Dale's behaviours.

1.17 Judith discovering these thefts and Dale's lies and confronting him directly threatened his power and control, significantly increasing the risk to her.

2. Judith and Dale's Relationship

Overview

2.1 Friends and family spoke about how Judith loved Dale very much and they recall them spending happy times together. They were both very musical and would play the guitar and sing together. Friends also remember them hiring a car and going away together for a few days to visit the places they'd been on family holidays. They also spoke about how Dale would help his mum e.g. putting a fence up in her garden and mowing the lawn.

2.2 F1 explained how Judith would be excited when she had made arrangements for Dale to visit especially when Covid restrictions were eased in 2020 and her and Dale would eat Fish and Chips in the garden together. However, friends also spoke about how Dale would let Judith down. They'd make arrangements and he would cancel or not turn up leaving Judith disappointed. Judith was also aware of how Dale would let her down. She kept a list in her 2017 diary of the visits Dale had made and when arrangements had been cancelled or Dale just not turned up.

2.3 Whilst friends and family spoke about Judith being ready to fight Dale's corner, to defend him and not wanting people to think badly of him, her diary entries and communications with friends show how cross she becomes with Dale at different points in the timeline. At these times she doesn't attempt to defend him but appears shocked, angry and upset at his behaviours. Judith's diary entries indicate that she recognises that she has lost her family because of Dale's behaviours.

2.4 Judith writes in her diary on several occasions that she is unable to go to her fitness class or to the Social Club because she has no money and is waiting for Dale to repay what she owes her.

2.5 In June 2001 Judith reported to Dyfed Powys Police the theft of cheques/postal orders from her home that had then been cashed at a local Post Office. Dale was arrested at his father's address and when officers searched his room, they found the stubs from the postal orders. Judith did not

wish to support a prosecution and Dale received an Adult Caution for Theft from a dwelling and three counts of Obtaining Property by Deception.

2.6 F3 had notes of an incident that Judith had told her about two years prior to her murder. Judith told her that Dale had frightened her. She had to make him get out of her flat and had told him not to come back. She said that Dale had been swearing and blaming her. This is the only time that Friend 3 had heard Judith being frightened of Dale.

2.7 Following arguments with Dale, Judith describes herself as *low in spirit, miserable, lonely and cross.* Dale spends Christmas with Judith in 2017 but it is not an enjoyable day for Judith as Dale spend most of the day in bed with a cold and doesn't help her with cooking Christmas dinner or washing the dishes. She writes *I would have been less miserable on my own.*

2.8 At times in her diary entries, Judith recognises that Dale only visits when he wants something, usually his money or his 'baccy' and she tells Dale this.

2.9 Judith's friend said about Dale: *He would tell such terrible lies.*

2.10 When Dale returned from university, he told Judith and H1 that he was working at a care home in a nearby village. Judith would go to the Care Home every morning at 8am to bring Dale home after his night shift. One night whilst Judith believed Dale to be in work a parcel arrived for him and she took it to the care home. She was told by staff that they had never heard of him.

2.11 He told his parents that he was completing a Post Graduate Certificate in Teaching. Judith writes in her diary how excited she is to be going to Dale's graduation only for him to tell her days before that he's not going to the ceremony, disappointing her.

2.12 He then tells them that he has a job in a local school and each day he leaves the house to go to work returning in the evening. It is only when Judith speaks to a friend of hers who works in the school that she finds out that Dale is not working there. She confronts Dale about this and writes about it in her diary in January 2017: *Dale admitted he didn't graduate, didn't have a job. Tried to blame his childhood. NO. Says he has an appointment with Doctor next week.*

2.13 It is evident from Judith's diary entries that she wants to help Dale to address his lying and other behaviours and sees the GP as a trusted professional to seek this help.

2.14 In June 2020, during a telephone conversation with F3 Judith is very upset and says;

- *My son needs help. He doesn't know the difference between fantasy and reality. Been here telling stories. I challenged him. He says he can't help it.*
- Judith tells F3 that she wants him to get help and has offered to go with him but *how can you make someone who is twice as big as you see the GP.*

2.15 The pattern of deceit and Judith's growing concerns about Dale's lies continue throughout 2020:

- Judith's diary entries in May 2020 note that Dale has told her that he's been furloughed from his job at the residential home for young people. In July, Dale tells Judith that he is back in work. Judith questions this in her diary on the 14th July when she writes: *Concerned that Dale is here quite a lot. Is he telling H1 that he's at work?*
- He maintains the pretence of being back in work telling Judith of things that are supposedly happening in the care home which she notes in her diary up until September 2020. Dale's employer confirmed that his contract was ended in April 2020.
- Between August and November 2020, Dale tells Judith that he has bought a new car. Judith is suspicious about what Dale is telling especially when he asks her for her bank card to pay for the insurance which she refuses. In her diary entries from September to November 2020 Judith refers to it as the *imaginary car.*
- On the 18th November Judith writes again: *Dale has spent a lot of time here. I do wonder if H1 knows where he is. Says he does.*
- On the 20th November 2020 Judith writes: *Rang H1. He said that Dale was at work today. Didn't know he was on furlough. Just what I thought. Car – knew nothing about it……Dale came in. Told him H1 and I speaking so don't play us off against each other.*
- In a series of messages to F2 that same day she writes: *Dale arrived home while I was talking to H1 which is good. I want to stay in touch with H1. Did suggest that and he said yes. But there was one huge story. I just can't get my head around it. Tonight, I feel I want to take my key off him, cut ties but he's my only family……I think Dale needs psychiatric help.*
- On the 23rd November Judith writes: *Tried to talk to Dale about the lies but he says he can't talk about things*

2.16 It's clear from her diary entries that Judith thinks Dale needs help and her friends say that no matter what Dale did or how he treated her, Judith thought she could help him.

- F4 said: *It was the lying that upset her the most – she never knew if he was telling the truth*
- F3 said: *She always wanted to believe what Dale said….she wanted to trust him.*

2.17 There is no further information given to F2 in November 2020 about the nature of the *one huge story* referred to in her messages and Judith doesn't

write about it in her diary. It is the Panel's view that this story, whatever it was, was significant enough for Judith to write that she wants to take her key off Dale and cut ties with him but the fact that she considers him her only family prevents her from doing so. Again, Judith indicates that she feels Dale requires psychiatric help but when she tries to speak to him about him a few days later he doesn't want to discuss it.

2.18 Friends, family members and Dale's ex-partners all reference Dale's relationship with money. It is also a key factor in Judith's relationship with Dale.

2.19 On the 20th November 2020, Judith writes in her diary that she has ordered a new card reader so that she can make online payments in the lead up to Christmas. The same day she writes:

I checked my app – money missing from both accounts. £150 gone from savings and £142.95 from Debit. Rang Dale – admitted it. Said he'd repay me Monday. I feel really betrayed. Dale abused my trust with debit cards when I couldn't walk. Also taken savings card out of my purse. Don't know how he had PIN – must have gone through contacts.

2.20 Between the 20th November and 2nd December 2020 there are daily entries in Judith's diary where she has asked Dale for her money and he has given excuses about when he will pay her back.

2.21 Judith writes in her diary on the 26th November 2020 *Dale asked if he could listen to audio book on my phone – NO! Can access too much.*

2.22 On the 30th November Judith writes: *I am paranoid. Constantly checking my purse and bank phone app.* In her last diary entry on the 2nd December 2020 Judith writes *Money sorted*.

2.23 Between December 2020 and his arrest in February 2021 Dale steals over £2700 from Judith by withdrawing cash from her account and making online payments/transfers to himself. At the time of his arrest Judith's account is overdrawn.

2.24 He lies to friends and to a range of professionals including the police, pharmacy staff and housing wardens in an attempt to conceal his murder of Judith.

<u>Analysis</u>

2.25 The relationship between Judith and Dale was complex with conflicting emotions. It is clear that Judith loved Dale and was desperate to help him. But at the same time she was determined and forthright and she did not shy away from challenging him about his lies and stealing, pursuing repayment with

varying degrees of success. She did this despite, at times, being frightened of him.

2.26 Her diary entries evidence that she wanted to feel proud of him (graduation, having a job) but was often let down. For Dale the relationship would, albeit as a result of his actions, veer from love and pride from his mother to disappointment.

2.27 Judith was not a wealthy women. Having returned from Cyprus with nothing her only income was what she received from pensions and benefits which amounted to just over £1000 a month. So the thefts have material consequences for her well-being and the quality of her life both in terms of what she can buy and whether she could exercise her hobbies and interests (e.g. not being able to afford food or go to the gym).

2.28 The pattern and consequences of Dale's behaviours and the resultant confrontations and challenges meant that his relationship with Judith was one of significant fluctuation and recurring periods of conflict.

3. Friends and Family Members Views about Dale

Overview

3.1 Friends, family and Dale's ex partners consistently describe him as a compulsive liar and someone who could come across as completely plausible in that his lies would be matter of fact and detailed.

3.2 Family members recall Dale stealing the donations made towards his grandmother's funeral. Dale was told that he needed to return the money. On the morning of the funeral Dale turned up with postal orders for the amount that he had taken and was told that he needed to return cash not postal orders. The cash was returned by Dale a few days later but it is understood by family members that he had stolen and cashed a cheque from Judith to repay the money.

3.3 F2 recalls Dale stealing petrol money that Judith had left in the kitchen and in 2014 Dale stole the money that Judith had saved to move to the flat which she had hidden in her flat.

3.4 Dale's ex-partner recalls him being in control of the money and spending it rather than paying the rent and bills.

3.5 Judith keeps a list in her diary of the money that she has lent to Dale during 2020, what amounts he repays and when. Friends were aware that Judith lent Dale money and told the Chair that Judith would say that she *didn't know*

what he did with money. She notes in her diary that she gives him money for cigarettes as *he gets nasty if he doesn't have cigarettes.*

3.6 F1 told the Chair that she was aware that Judith lent Dale money and would then have to try and get it back from him. At times she was waiting on this money from Dale so that she could buy food.

3.7 Judith writes in her diary on several occasions that she is unable to go to her fitness class or to the Social Club because she has no money and is waiting for Dale to repay what she owes her.

3.8 Friends spoke about how Judith was worried about Dale getting hold of her phone as he knew how to access her online banking apps.

3.9 Friend 3 recalls one occasion when she had lent Judith money over a Christmas period and Judith had asked if she could have the money in coins rather than notes. The reason given by Judith was that it was easier to manage coins when giving them to Dale as she wouldn't get any change if she gave him a note. Friend 3 is aware that Judith lent money to Dale and the difficulties she had in getting Dale to repay. When F3 is told that Judith is in hospital in January 2021, she was worried that Dale maybe accessing her accounts and stealing from her.

Analysis

3.10 The views of friends and family provide independent third-party accounts of the degree to which deceit and economic abuse was a central feature in Judith and Dale's relationship.

3.11 It is the view of friends and family that Dale saw Judith's money as accessible. This is in contrast to H1 who they believe to have fitted a lock to his study and a safe to prevent Dale stealing from him.

3.12 In a sad reflection on Judith and Dale's relationship F4 said *The lies, the money….it was the price she paid to keep the relationship going.*

4. Judith's Health, Well-Being and Medication

Overview

4.1 Judith suffered with respiratory conditions through her adult life including Chronic Obstructive Pulmonary Disease (COPD) and asthma, both of which restricted her mobility. Judith also had diagnoses of osteoarthritis, ulcerative colitis and hypothyroidism. She was prescribed regular medication, one of which was a controlled drug Gabapentin.

4.2 Her diary entry on the 8th November 2017 is the first reference to Dale stealing her medication: *Dale had found my gabapentin and taken them.*

4.3 There are further instances in 2020 when she writes;

- *9th May 2020: Dale arrived – wanting gabapentin*
- *23rd May: Big argument with Dale – he has found key for box and taken gabapentin. Really cross he must have been searching in drawers etc for keys. Feel violated.*
- After Judith's fall at home in October 2020 she is prescribed Oromorph for the pain in addition to her regular medication. Dale is staying with her at this point.
- On the 19th November her diary entry states: *I discovered gabapentin box only had 1 card not 6. Really told Dale off. I need those tablets. Said new script ready Monday?* This theft of her medication occurs at the same time as Judith discovers money has been stolen from her accounts and she expresses how she feels betrayed that Dale has gone looking for her medication whilst she was immobile due to the fall.

4.4 Judith records in her diary between the 23rd November and 2nd December that she is in pain and it appears that Dale is withholding her medication;

24/11/2020	*Dale arrived. Said I wouldn't be having my script.*
25/11/2020	*Rang Dale. Said I'd be furious if I walk to the (pharmacy) and there's no script…….Dale turned up after 2. Said I can't have more tabs.*
27/11/2020	*Missed bus so walked to BM then to Pharmacy. 9th in queue!! No script. Walked home. HURTING!!*
2/12/2020	*Txt from Dale – script won't be there. Put my tabs on his name!!*

4.5 Judith falls on the 16th October 2020 and on her discharge from hospital she is immobile and in considerable pain writing in her diary that Dale had helped her out of bed and that she can't sit for long.

4.6 On the 23rd October 2020, Wales entered a two week 'firebreak' in response to the ongoing Covid pandemic. Dale moves in with Judith and Judith states that he will be her *care bubble* and therefore allowed to stay with her. She writes in her diary that she is *so glad that Dale is here….thank goodness Dale is here. I couldn't cope without him.*

4.7 After coming out of hospital in October 2020 Judith writes in her diary that she has stayed in her nightclothes for three days– the only time she has done this in the time covered by her diaries. Understanding how Judith prided herself on her appearance and the routine she had of waking, dressing and putting on her make up this gives an indication of how unwell she must have felt.

4.8 A further indication of this is the fact that Judith only makes one diary entry between the 28th October and the 5th November stating that the medication (she is prescribed Oromorph at this time) is making her very sleepy. She states that Dale is staying over and doing the washing, shopping and looking after Ruby during this time.

4.9 The Chair noted that P2 had asked whether Dale was living with Judith at the time he killed her. He stated that *Dale had a huge amount of rage directed at Judith for no apparent reason.*

Analysis

4.10 It is the Panel's view that Judith was vulnerable in the period following her fall and she depended on Dale to do household tasks and look after Ruby. The Covid firebreak further increases Judith's isolation as friends are unable to visit her.

4.11 These circumstances enable Dale to move into Judith's space, something that she hasn't allowed previously. Whilst he'd stayed over previously this has never been more than a couple of nights as he would have to sleep on the sofa due to the flat only having one bedroom.

4.12 Judith being unwell and Dale staying in her flat provided him with the opportunity to steal money and medication. There was no need to ask as he may have done previously, he helped himself with a sense of entitlement. At this point more than any other Dale holds the power and control in the relationship with Judith.

4.13 When she becomes aware of his stealing at the end of November and confronts him he continues to use her vulnerability to exert control through denying her access to her pain medication and delaying the payment of the money he has stolen from her. It appears from Judith's diary entries that Dale's behaviours had been escalating in the weeks leading up to her murder with her discovering that he had stolen money from her accounts and her pain relief medication.

4.14 Those who knew Judith firmly believe that she would have confronted Dale again if he had failed to bring her the money he owed her on the 2nd December. Her diary entries and communication with F2 indicate that she had done exactly this on the 20th November. From her diary entries, it is clear that she is angry with Dale for what he has done and tells him she wants her money back. He promises to bring the money on three occasions in the week before the last entry in Judith's diary. His text to Judith on the 2nd December saying *Money sorted* would have led her to believe that she was having her money back when he came around to her flat later that day.

4.15 It is the Panel's view that Dale's economic abuse of Judith had gone on for so long that it potentially masked the escalating risk to her in terms of his coercion and manipulation. It is also the view of the Panel that their close proximity due to covid circumstances removed the opportunity for any cooling off period that had previously enabled Judith to have some distance from Dale and the benefit of her own safe space.

4.16 These factors significantly intensified the abusive and controlling dynamic of their relationship and resulted in an escalation in Dale's behaviours because of the opportunities that living with Judith afforded him. Reflecting on what P2 said about Dale, it is the Panel's view that, on arriving at Judith's flat he did not have the money he owed to her and she challenged him on this. He had once again lied for over a week in relation to paying back the money including the text she received on the 2nd December. It is the Panel's belief that Dale's response to being confronted by Judith for his lies has been to kill her.

4.17 Dale's abuse would now fall within the definition of Economic Abuse provided by the Domestic Abuse Act 2021

"Economic abuse" means any behaviour that has a substantial adverse effect on person's ability to—
(a)acquire, use or maintain money or other property, or
(b)obtain goods or services.

4.18 Friends believed that Judith knew what he was doing was unacceptable but they repeatedly stated that she wouldn't have recognised it as abuse and that she would not have been able to objectively foresee that his moving in with her would lead to an escalation in his behaviours.

4.19 In addition, in the time leading up to her murder it is important to note that she was unwell, in pain and without access to her medication so her awareness of risk and the mechanisms by which she had kept herself safe previously may have been impaired.

5. Health Services Involvement with Judith

Overview

5.1 Judith attended the GP practice on a regular basis, following registration with the surgery in 2013. She was in contact with the GP surgery until November 2020, attending in person or receiving advice and support via the telephone at least every two months throughout this time period. Judith was known to suffer with respiratory problems, namely chronic obstructive pulmonary disease and asthma, which restricted her mobility. She also had diagnoses of

osteoarthritis, ulcerative colitis, and hypothyroidism; she was prescribed regular medication, one of which was a controlled drug - Gabapentin[38].

5.2 Judith received care from various specialists within acute health services related to new and ongoing physical health concerns following referrals made by the GP practice during this time. This included foot surgery, treatment for vertigo, referrals to the Ear, Nose and Throat Clinic and eye surgery for removal of cataracts.

5.3 Judith also attended the Emergency Department in 2017 for a wrist injury, in 2018 with a shoulder injury and in 2019 for a back injury, all following reported falls at home.

5.4 Judith was not known to any mental health services and had no history of mental health concerns.

5.5 The GPs interviewed for this review recall Judith attending the surgery for medical care, but do not recall ever seeing her with her son Dale. They do not recollect any significant concerns or disclosures made relating to her safety or wellbeing.

5.6 The secondary care health records for Judith indicate that she was asked about domestic abuse on three separate occasions when she attended the hospital for treatment.

- In August 2019, Judith was asked safeguarding questions as part of the preoperative assessment by nursing staff prior to day surgery. These questions were as follows;

- Are there any concerns regarding significant others while the patient attends hospital?
- Is there a concern that there may be an adult/child at risk? (Consider if they are adult at risk of abuse or neglect, consider domestic abuse)
- Does the patient express concerns for their safety?

Judith's response was recorded as no to all three questions.

- In October 2019, Judith attended the hospital for a pre-operative assessment. The notes record routine enquiry questions being asked, and these questions were as follows;

[38] Following concerns about the abuse of this medication in 2018, Gabapentin and Pregabalin were reclassified in 2019 as a Class C Controlled Substances and is now a schedule 3 drug under the misuse of Drugs Regulations 2001 and The Misuse of Drugs Act 1971. They are exempt from the safe custody requirements. Healthcare professionals should evaluate patients carefully for a history of drug abuse before prescribing Gabapentin and observe patients for signs of abuse and dependence.

- Does anyone at home physically hurt you?
- Does anyone else in your home insult, talk down or try to control you?
- Do you ever feel threatened in your current relationship?
- Does your partner/ ex-partner or anyone else at home shout, swear at you so that you feel unsafe?

Judith's response was recorded as negative to all four questions.

- In October 2020, when Judith attended the Emergency Department following a fall, the reviewing Doctor has recorded that she was 'disturbed when talking about discharge, lives alone'. There are no specific details of what these concerns were, but it is later noted she was worried about finding transport home as she had no money which may have been the reason for her reported distress. During this attendance, the following safeguarding questions were also asked by the nursing staff;
- Are there concerns for safety?
- Are there concerns about sexual abuse?
- Are there concerns about violence against women?
- Are there concerns about domestic abuse?
- Any concerns there may be an "adult or child at risk?

The notes record negative responses to all of the questions.

5.7 These safeguarding questions are part of the nursing assessment of care and are completed on every inpatient across the Health Board. The evidence of questions being asked is noted by the Panel as complying with expected practice and Health Board policy. Handwritten notes were used to record this information, however, since April 2021 NHS Wales digitalised the nursing care record. The aim was to standardise nurse record keeping across NHS Wales and provide a more efficient and accessible process for inpatient assessment. Hywel Dda University Health Board were involved in the pilot and roll out of the Welsh Nursing Care Records (WNCR).

5.8 All staff who have patient contact should attend mandatory training on the safeguarding of adults and children in accordance with the relevant Intercollegiate Documents and National Violence against Women Domestic Abuse, and Sexual Violence Training Framework including 'Ask and Act'[39], a requirement of the Violence against Women, Domestic Abuse and Sexual

[39] Ask and Act is a process of targeted enquiry across the Welsh Public Service introduced by Welsh Government. 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 individuals whether they have been affected by any of these issues.

Violence (Wales) Act 2015. This training is currently being revised by the Health Board in conjunction with the Public Health Wales Domestic Abuse Network.

5.9 The Health Board have implemented an 'Ask and Act' policy that complements the training and provides guidance for all Health Board employees and volunteers to recognise and respond effectively to indicators and disclosures of violence against women domestic abuse and sexual violence.

Analysis

5.10 Whilst there is evidence of routine questions being asked in 2019 and 2020 the Panel considered the effectiveness of *how* and *when* the questions are asked as important as the questions themselves being asked.

5.11 The Panel considered the language of the questions asked and how this focuses primarily on interpersonal violence and also how older people are less likely to identify with the language associated with domestic violence and abuse.

5.12 It is the Panel's view that the existing Ask and Act training doesn't allow enough time for practitioners to explore different approaches to asking the questions or how the questions require adapting for different groups in particular older people and those experiencing familial abuse. Including these elements within the training would result in practitioners feeling more confident in identifying and responding appropriately to older people who may be experiencing abuse.

5.13 During hospital attendances in February and October 2020 it is noted that Judith is anxious about returning home.

- In February it is noted: *Judith reports being anxious about going home and states her son will support.*
- The October record states: *Patient concerned about transport home as does not have any money. Noted prior to discharge felt 'disturbed talking about discharge, living home alone'.*

5.14 It is understandable that Judith may have felt anxious about returning home following surgery and the fall. The Panel considered whether further questioning may have identified any particular anxieties and explored why Judith didn't have any money. It is noted however that Hospital staff arranged

transport via the Red Cross and a referral was made for support at home both of which appear to respond to the needs recorded on Judith's notes.

5.15 Following Judith's foot surgery in February 2020, Dale was noted to be present at the property on two occasions when health care workers visited and was noted to be providing care for her. Judith was also seen on her own during some of these visits. There is no evidence that Judith was directly asked about any safeguarding issues during any of the visits when she was alone nor are there any documented concerns relating to safeguarding or domestic abuse. Judith also referenced receiving support from her son when a nurse discussed further input from the service in her discharge from community services, which further suggests that Judith considered Dale as an integral part of supporting her independence on discharge from hospital.

5.16 Dale is considered by both Judith and Health practitioners to be a supportive factor after she is discharged from hospital. Whilst Judith may not have recognised herself as a victim of abuse and neither are there any indications to practitioners from the safeguarding questions, the Panel considered the findings of a previous DHR in Pembrokeshire where practitioners had not considered the possibility of a family member perpetrating abuse. The SafeLives Report published in 2016[40] 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.

5.17 It is the Panel's view that this further highlights the need for bespoke and tailored training relating to older people's experiences of abuse to be made available to professionals working across Pembrokeshire and the wider Mid and West Wales region.

5.18 Whilst the National Training Framework and application of Ask and Act is being rolled out within their 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 and the further challenge presented by the fact that there is no statutory or policy requirement for GPs to routinely enquire about domestic abuse.

5.19 At the time of this Domestic Homicide Review, Judith's GP practice had not completed the Violence against Women Domestic Abuse and Sexual Violence training aligned to the National Training Framework including Ask and Act.

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

This is a similar finding to the DHR completed in 2022 for Pembrokeshire by the same Chair.

5.20 The Panel is concerned that this training has been available since 2018, initially delivered monthly to priority groups and bi-monthly to all other services including Primary Care and yet neither of the two Practices involved in the DHRs completed in 2022 have completed the training. Furthermore, the Panel is concerned that there has been little oversight or monitoring of the update of this training by GPs.

5.21 Prior to 2019, awareness of identifying and responding to domestic abuse was incorporated into other Safeguarding training and delivered by the Health Board's Safeguarding Team. In 2018/19 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 however, it is not known what the uptake from primary care was partially due to the fact that as independent contractors, they do not have an Electronic Staff Record which records all mandatory training for Health Board employees. Since October 2021, the Health Board has been able to offer Ask and Act training weekly to staff and currently just over 50% of staff requiring this competency have completed the training.

5.22 A recommendation was made in a previous Pembrokeshire DHR (2018) that **GPs should be a priority for Ask and Act training.**

5.23 The DHR for Pembrokeshire completed in 2022 further recommended that **Primary Care improve compliance with Group 2 Ask and Act training and establish a mechanism for monitoring and reporting compliance.** To ensure that all relevant staff across Primary Care are trained and implementing Ask and Act it was agreed that an Assurance and Exception report would be presented to the Health Board's Strategic Safeguarding Working Group outlining compliance, areas for improvement and recommendations.

5.24 Further recommendations were made in the 2022 review that the Panel have included again in respect of Judith as they continue to be highly relevant to ensure improved outcomes for individuals who disclose domestic abuse in a health setting.

6. Health Involvement: Dale

<u>Overview</u>

6.1 Prior to the commencement of the timeline, Dale was receiving treatment for a chronic lumbar spinal problem, managed with controlled drugs.

Mental Health Services

6.2 He had been known to Mental Health services in 2011 when he had an initial assessment by the Crisis Team following an overdose of insulin (his aunts' treatment). At the time of admission Dale is reported to have said that he wanted to die and that he had experienced a difficult year including the breakdown of a relationship. He reported financial problems with work sporadic some friends turning their backs on him. He also described an accumulation of worries including a relationship breakdown with his father and some issues about being gay. He reported that he was going to move to Cyprus to be with Judith and had given up his property which he felt was a mistake but that he could not tell his mother.

6.3 He stated that he realised that this was a mistake, he now wanted to live and reported plans for the future. He was advised to contact his GP if feeling low or if he needed a referral to the Community Mental Health Team.

6.4 He was discharged from the service a day after admission and there is no further evidence that Dale was either referred or accessed any other support for his mental health following this.

6.5 During this admission in 2011, the medical records note that Dale was previously employed in a psychiatric role, this was queried to be a Community Psychiatric Nurse Role (CPN). There is no evidence of Dale ever being employed in mental health services recorded in any of his medical records and it is the Panel's view that this was another example of Dale's lies.

Primary Care Services

6.6 Dale had frequent contact with Primary Care services. The GPs interviewed described him as always polite and friendly, his appearance was well-kempt and his behaviour was never aggressive or demanding.

6.7 Dale was prescribed controlled drugs for chronic pain back pain, which was managed at times by the issuing of daily prescriptions due to the frequent periods where medication was used earlier than prescribed. Once the frequency of collection was extended, he often returned to overuse of this medication, resulting in a need to further revert to prescriptions collected on a daily basis.

6.8 Dale gave many different reasons for why he required his medication early, including travelling for employment or long-distance holiday plans. However, these explanations were noted by the GP practice to be inconsistent and on one occasion, the surgery did ask for verification of travel plans prior to issuing his medication early.

6.9 One of the GPs remembered an incident where he challenged Dale about inconsistencies with his account of travel arrangements. He recalls that Dale became evasive, and appeared flustered, subsequently his request for earlier medication was not issued.

6.10 Dale was encouraged to undertake self-help measures, such as exercise and heat treatment, and one of the GPs interviewed remembers advising him to self-refer for counselling support. It is unknown whether he took up the counselling support.

6.11 At times Dale mentioned becoming more active including walking and swimming and reported that he found the use of other non-prescription medications helpful however this was inconsistent and at other times he reported that these were ineffective, and he required stronger analgesia such as Oramorph or Diazepam.

6.12 The difficulties in managing Dale's misuse of medication were discussed during the meeting with the GPs for the purpose of the Health Board's IMR. The use of multidisciplinary meetings was discussed as a mechanism for discussing patients with complex medical problems but as Dale was not open to any other service this mechanism was not deemed an appropriate response for his management.

6.13 There is evidence of good practice in the GP's response to managing Dale's medication. The GP practice had ensured where possible for Dale to be seen by the same GP. This GP had several discussions about Dale's misuse of medication with the GP Lead for Substance Misuse within the practice. That GP Lead worked as a GP with Special Interest who was often contacted by GP colleagues across the county to provide management advice and support regarding complex prescribing challenges.

6.14 Between September and November 2017 Dale presents at the Out of Hours GP on four separate occasions requesting pain medication and is prescribed Pregabalin; The third and fourth presentation at Out of Hours were during a period when he was on daily prescriptions from the GP for pain medication. Enquiries were made as to whether the Out of Hours Service would have had access to Dale's medical records to know what medication he was prescribed. The Associate Medical Director, Hywel Dda University Health Board

representing Primary Care on the Panel confirmed that the Out of Hours Service would have access to the Individual Health Record of the patient. It was further identified that on three of the occasions Dale was seen by the Out of Hours service it was by a GP from his own practice including the GP Lead for Substance Misuse who would have been aware of Dale's misuse of medication. On each occasion Dale was prescribed Pregabalin only until he could contact the GP practice during opening hours.

6.15 There was no evidence of referral of Dale to substance misuse services. This was discussed with the GP practice, who advised that Dale would not meet the criteria for referral due his controlled medication being managed by the GP practice. This decision was further explored with the Service Lead for the Community Drug and Alcohol Abuse Team (CDAT) who advised that as Dale was already receiving input from the GP Lead in this service, and in the absence of any other concerns regarding illicit use or known mental health concerns, this was likely to have factored in the decision to not refer in these specific circumstances.

6.16 On several occasions, Dale's medical notes record him as feeling positive, reporting him having plans for the future and that he was feeling that his pain was more manageable. Dale's mental wellbeing was also explored in the interview with the GPs. They stated they had not considered him to be low in mood, or suffering from any mental health concern, and therefore, they had no reason to consider referring him to mental health services.

6.17 In September 2019, GP records note a telephone contact with the local pharmacy regarding the fact that Dale had tried to obtain medication with an altered prescription. The GP practice requested that the Pharmacy report this incident to the Police and followed up with another discussion a week later where they challenged why such action had not taken place. This situation was discussed in the meeting with the GPs to explore why they had not felt it appropriate to contact the Police themselves when they were aware that the pharmacy had not done so. The GPs stated that they felt that, on receiving an altered prescription, it was legally the Pharmacist's responsibility to report the matter to the Police.

6.18 The management of Dale's medication was discussed with the Clinical Director/ Deputy Associate Medical Director, Primary and Community Care Services to consider whether Dale's management by primary care services could have been improved upon and to reflect on any other options available. As Dale suffered with a chronic pain condition and was frequently reportedly away his management was considered to be as appropriate as it could have been given these circumstances.

Chronic Pain Service

6.19 Records indicate that during an assessment by the Health Board Chronic Pain service in January 2017, Dale reported low mood, social isolation and sleep disturbances which resulted in a referral to mental health services being offered and accepted by Dale. However, there is no evidence that a mental health referral was completed. This was discussed with the Chronic Pain Service Lead Psychologist as part of the IMR process who was unable to account for why this did not happen. Dale was only seen once by this service and discharged after the initial assessment.

6.20 The Pain Management Service at that time was relatively new, which may have been a factor in how referral processes were not well established and why this referral to mental health services was not completed. The Health Board report that there have since been changes to the structure and delivery of this service, which now includes a Psychologist Lead and improved referral processes for mental health assessments.

<u>Analysis</u>

6.21 The information contained above indicates that Dale had a complex medical history over a long period of time. Namely:

- His suicide attempt;
- His overuse of prescribed medication;
- His lies and deception in order to gain access to further medication;
- His admission to the chronic pain service that he was not coping.

6.22 In addition, Judith wrote to Dale's GP in January 2017 to highlight her concerns. It is the Panel's view that Judith considered her GP a trusted professional, someone impartial and authoritative who she believed could help Dale. She writes as follows;

reference to my son, Dale. Both myself and Dale's father, (my ex-husband) are very concerned regarding to his past and recent behaviour, and his mental health. From his late teens, early twenties, Dale has had a history of lies, fabricated stories, eating disorder and stealing. His stories are usually in relation to failed academic achievement and failed employment prospect. Some examples of his stories are, he told his friends that he was unable to accept a position, as his mother had died. I had been in hospital, but very much alive. For several weeks, I had drove Dale to his night shifts at his residential care home, returning to collect him in the mornings, I then discovered that he was unemployed. I paid for tickets, for him and a friend, to spend Christmas with family in Plymouth, I waved them off. Weeks later, I had discovered that they

got off the train and returned to Haverfordwest, living rough, until they were due to return. These incidents happen and many more happen up to 10 – 20 years ago.

We thought that Dale had outgrown this period of his life. A few years he undertook a postgraduate teaching course, we were told it was going well and that his graduation was in August. I was unable to attend and was in hospital at that time. We were also told that he had been given a placement teaching in a junior school in Milford Haven. Due to some discrepancies in his conversations, I did some investigation and discussed that he had failed to qualify, he did not graduate and did not have a teaching post, or any other employment. He had been leaving his home in the mornings and returning in the evenings. We did not know where he spent his time, he will only say 'walking'.

We are very worried that he is once again lying and convincingly so. I believe that he is actually living his lies in his head. I have spoken with Dale, in the presence of his dad, he has admitted everything and says that he is relived that everything is in the open. He says that he will speak help, but he will only speak to you and seek help through you.

Dale is not aware that I am writing to you, I am aware and I acknowledge patient confidentiality, but I am not sure how much, if anything, Dale will tell you. I felt that it may be useful to the historical and current information, Dale lives with his Father, who has made it very clear that unless he speaks help with his behaviour problems, he will have to look for alternative accommodation.

6.23 There is no reference to the letter in Judith's file which may have allowed GPs to recognise the relationship between Judith and Dale. The GPs interviewed for the review had no recollection of the letter and there is no record of it ever being discussed with Dale or Judith. No explanation could be provided by the Practice as to why this letter was filed with no actions or follow up noted. This is an omission and possibly a crucial one.

6.24 The Associate Medical Director for Hywel Dda University Health Board representing Primary Care on the Panel and themselves a General Practitioner, stated that they would have expected the GP to have had a discussion with Judith in order to discuss confidentiality and seek her consent to share the information in the letter with Dale.

6.25 When interviewed for the review the GPs at the Practice stated that had the letter been received now it would have been discussed with the lead GP for that day and contact made with the person who had written it as well as discussed with the patient concerned.

6.26 It is the Panel's view that contact with Judith (and possibly Dale) following this letter, particularly if read in the context of Dale's full medical history may have provided an opportunity to have more detailed discussions with Judith and to explore treatment options for Dale or for referrals to be made to other services. It may also have enabled a discussion where it was identified that Judith was a victim of abuse including economic abuse from Dale and provided a pathway to services for information and support for both of them. It may also have resulted in communications with the pharmacy to block Dale's ability to access Judith's prescriptions in 2020. It highlights the need for services to respond holistically and collaboratively and to consider information held across agencies.

7. Pharmacist Contact – Judith and Dale

Overview

7.1 As part of this Review a discussion took place with a pharmacist who knew both Judith and Dale as part of the Health Board IMR process. Dale regularly attended the pharmacy to collect his own script and had, on occasions, also collected his mother's prescribed medication.

7.2 Judith's prescription contained medication that is classed as a Schedule 3 controlled drug (Under the Misuse of Drugs Act 2001). This does not require additional checks to be made, such as recording the name of the representative who collects medication on the controlled drug register.

7.3 The pharmacist recalled Dale collecting his mother's medication just prior to the discovery of the homicide and remembers Dale being asked by pharmacy staff about his mother's wellbeing. He was reported to have replied that she was unwell with the Covid virus or that she was away visiting friends.

7.4 A meeting also took place with the independent pharmacist who Dale saw frequently for his own medication. He recalls having several conversations with Dale and remembers him being always polite and pleasant. He also described conversations where Dale disclosed that he was not managing his pain and was supplementing his prescription with the use of cannabis. The pharmacist was not able to confirm the strength or the frequency of his cannabis use. Dale's admission of using cannabis appears to have not been shared with the GP practice however there is evidence of communication from the pharmacy to the GP concerning Dale's poor management of his pain which was followed up promptly with a medical review by the practice.

7.5 During the meeting with the independent pharmacist the incident where Dale presented an altered prescription was explored. Similar to the GP practice, the

pharmacist had not considered it necessary to report to the Police describing pursuing a criminal process as not being in Dale's best interests. The flagging of this to his GP practice was felt to be sufficient action as Dale's reasons for altering the script were likely due to his poor pain control which was then managed with daily prescriptions.

7.6 The pharmacist interviewed described the impact of the Covid 19 pandemic on the increase in patients accessing community pharmacy consultations and the need to further improve how information is shared between General Practice and community pharmacies.

Analysis

7.7 The pharmacy group are part of the Ask for Ani (Action Needed Immediately) code word scheme developed by the Home Office to allow victims of domestic abuse to access support from the safety of their local pharmacy. The Ask for Ani scheme also involves educating pharmacy staff on domestic abuse.

7.8 The pharmacist was aware that many of the staff had completed the Ask for Ani training initially, although due to the high rate of staff turnover some of the newer staff may have not received this training. Though there is no indication that any indicators of abuse or disclosures were made by Judith it is important that all staff who work in the pharmacies involved in this scheme are aware of how to respond effectively to disclosures or if a patient attends the pharmacy and asked to use the safe space, or 'Ask for Ani'. This was discussed with the pharmacist, who has agreed to discuss training compliance with the pharmacy manager to ensure all staff are fully trained on the Ask Ani scheme.

7.9 Not all pharmacies in Wales are signed up to the Ask Ani scheme, therefore not every pharmacist would have received this additional training on domestic abuse. This was discussed with the Senior Lead for Primary Care and Community Pharmacy Service for Hywel Dda University Health Board who advised that Health Education and Improvement Wales (HEIW) provide training that is mandatory and closely monitored for compliance including safeguarding of adults and children. However, it was not clear at the time of the meeting as to how well this training addresses awareness of domestic abuse including the indicators and how to signpost victims for support and meets compliance with the National Training Framework.

7.10 It is the Panel's view that schemes such as Ask Ani which are located in communities present safe opportunities for individuals to seek support but that their effectiveness relies on public awareness and the knowledge and confidence of staff to respond appropriately.

7.11 There appeared to be a lack of understanding by the pharmacy and the GP practice of the correct action to take when there is evidence of altered prescriptions. This needs to be explored further by the Health Board medicines management team.

7.12 Whilst there is evidence of some effective communication between the GPs and the pharmacist involved in the review there is a need to make these processes more robust, with clearer lines of communication and record keeping between GP practices and community pharmacies when information is shared. This has been already been highlighted to Welsh Government and a proposed electronic information sharing database is currently under development.

8. Dyfed Powys Police

Overview

8.1 On the 18/6/2001 Judith reports that cheques/postal orders have been taken from a room within her house and cashed at a local Post Office. The report is crimed as theft from a dwelling and 3 x obtaining property by deception as it appears that Dale had taken the items whilst as a visitor in the house rather than 'breaking in'.

8.2 Dale was arrested and when officers searched his room at his father's house the stubs from the stolen postal orders were found. Judith did not wish to support a prosecution and Dale received an adult caution for the offences. This incident was not recorded as domestic abuse and no domestic abuse notification was completed.

8.3 A Home Office Circular dated May 2000 to all Chief Police Officers in England and Wales states the following in relation to the definition of Domestic Abuse;

Domestic violence is not a specific statutory offence. The term is used to describe a range of criminal offences-and sometimes sub-criminal behaviour-occurring in particular circumstances. There are therefore many different definitions. The two most significant nationally are as follows:

For use in Force returns to HMIC

"The term domestic violence shall be understood to mean any violence between current or former partners in an intimate relationship, wherever and whenever it occurs. The violence may include physical, sexual, emotional or financial abuse."

For the purposes of Best Value performance indicators for 2000/01

"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender"

These are important for national statistical purposes but are not intended of themselves to affect police operational policy or to prevent the local use of different definitions where these are thought appropriate for particular local circumstances and purposes.

8.4 From the statements in the Home Office Circular, it appears that Police Forces were only required to report to HMIC in relation to the first definition detailed above which, in 2001, did not include family members.

8.5 The Circular also allows for the use of different definitions of domestic abuse to be used at a local level. The Chair requested a copy of the Dyfed Powys Police Domestic Abuse Policy for 2001 to understand what the working definition was for the Force at that time and how responses related to that. The policy in operation in 2001 was unavailable and the earliest available document was the 2008 policy which referenced the Association of Chief Police Officers definition at the time which included family members but this is seven years after the incident reported by Judith.

8.6 It is the Panel's view that the definition operational in Dyfed Powys at the time of the crimes reported by Judith was that of current or former partners in an intimate relationship and therefore no domestic abuse related crime would have been recorded or subsequent notifications submitted.

8.7 In the event of such reports being made to Dyfed Powys today the following observations are made:

- Judith's reports would amount to economic abuse in line with the definition set out in the Domestic Abuse Act 2021 and be recorded as a domestic abuse incident
- Since at least 2008 in Dyfed Powys, Judith's relationship with Dale would have resulted in a similar report to Dyfed Powys Police being categorised as Domestic Abuse
- An incident being categorised as Domestic Abuse would have required officers to complete a Domestic Abuse, Stalking and Harassment Risk Indicator Checklist[41] with Judith and a referral pathway to services dependent on risk identified. (see section in relation to effectiveness of tool with older people and interfamilial abuse)
- Categorising an incident as Domestic Abuse and explaining this to Judith may have been the first occasion that Judith has heard Dale's behaviours

[41]https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

referred to as domestic abuse and recognising her own experiences as someone who was experiencing domestic abuse
- Flag on the system that would subsequently have been known to Police when reports for concerns for Judith's welfare were raised in 2021.

Responses to concerns raised by Judith's friends in January 2021 and February 2021

8.8 At 13.47hrs on the 24th January 2021, F1 contacts Dyfed Powys Police concerned that she has not seen Judith. She states:

"I'm concerned about a neighbour and a lack of her being around. I haven't seen her physically since the beginning of December."

8.9 She reports that all the windows in Judith's flat are open and shares her concerns about the inconsistencies in Dale's accounts for Judith's whereabouts e.g. unwell, visiting a friend, in hospital.

8.10 F1 clearly recalls telling the call handler both at the beginning and end of the call that she wished to remain anonymous and was adamant in her conversation with the Chair that she was assured that her name would not be mentioned due to data protection. She recalls this clearly as she had been advised by a friend to reiterate this and seek assurance as she was uncomfortable with Dale finding out that she had made the report.

8.11 A STORM incident is created by Dyfed Powys Police in relation to this call by F1. Judith's vulnerability is noted and the local Hospitals are checked with Judith not being in any of them. At 14.05hrs the log is updated by a Police Officer working from the station nearest to Judith's home that she has spoken to H1 who says that Dale has been living with Judith since the 22nd December.

8.12 At 14.21hrs the officer records that they have spoken with Dale and that he is at the address with Judith as they are isolating together (this was during a period of lockdown in January 2021). Dale tells the officer that Judith has severe asthma and chronic COPD and that she has a GP telephone appointment the following morning to assess. Dale further states that Judith has been hospitalised due to her condition and *she would be breathless just trying to get herself from the bed to the bathroom and needed help with most tasks and was in the most part bed ridden or certainly, at that time, she had taken to her bed.*

8.13 Dale then asks the officer *Is it F1?*

8.14 The incident log states: *Dale will go into the rear garden and shout over to Ms C to let her know that all is well... I have also updated Ms C on her mobile*

number - as I am typing this, Dale is at her window! No need for police attendance [sic] at location".

8.15 The Officer records that she then contacted F1 to update her of the explanation provided by Dale. In her account to the IOPC the officer states that

She (F1) was appreciative of this and thanked me for my call and it was my impression from this conversation that she was happy upon receiving this information that Judith was being cared for... as we were speaking she said words to the effect of "oh I can see Dale now... I'll go out and have a chat with him" – she thanked me again and I ended the call'.

8.16 F1 recalls how, on seeing Dale whilst she was on the phone to the officer she felt vulnerable and frightened. She spoke to Dale who stated that Judith was in hospital and because of Covid nobody was allowed to visit her.

8.17 The following evening after her husband had left for work Dale came to F1's house asking if she could open a tin for him. F1 was on her own and she told the Chair that she was frightened and nervous when Dale had come to the house. He'd never done it before and he would have known that she was on her own as her husband's van was gone. When he left she barricaded the front and back doors.

8.18 It is noted in the IOPC report that the Officer recalled

Dale was attentive and concerned for his mother, that he was calm and polite and helpful on the telephone, he did not seem to have any awareness that I would be making contact with him but nor did he seem caught off guard when I asked him about his mother's welfare. The conversation flowed naturally and easily and he was very plausible. It was my perception at the time that should I have asked to speak with his mother or ask[ed] to go around there and visit her in person that he would have been more than willing for me to do so.

8.19 The second reported concern happened on the 19th February 2021. F3 contacts Dyfed Powys Police to report concerns for Judith. "*Oh hello, can I tell you a story please, I'm worried about a lady in Pembroke Dock".*

8.20 In the call, she states that she and another friend have been unable to contact Judith by telephone or text message since 23 January. She reports that another neighbour had knocked on Judith's door and made contact with Dale. She explained: *"The son phoned me back and told me his mother was in hospital 3. Subsequently, I spoke to him on the phone now and again and two weeks ago he said oh they transferred her to hospital 4 two weeks ago. There have been a couple of phone calls and he's said she's been discharged home but she didn't come home. Yesterday afternoon he phoned and said she will come home from hospital 4 today. I phoned hospital 4 at 9 o'clock this*

morning, gave the ladies name and the spelling of the name, they could not find her name, they said they had no record of that lady.

8.21 The call handler asked whether the caller had spoken to the son today. In response, F3 said: "*No, I didn't speak to him because I don't trust him you see.* Call Handler asked why she didn't trust him and F3 replied: "*Because she [Judith] didn't trust him, she used to tell me about him".* Call Handler then asked F3 why she thought her friend wasn't in hospital. F3 stated again that Hospital 4 had told her they had no record of her name. Call Handler then said: "*they are obviously restricted due to Data Protection as well of what they can say."* Call Handler asked F3 how the police could help her. She replied that she wondered whether the police could *"follow up"* with Hospital 4. The following conversation then took place:

Call Handler: "*Right, you want us to go to hospital 4?"*

F3: "*Well I can't get anywhere with hospital 4. They are saying they can't find her name*."

Call Handler: "*Right, ok well obviously it's a different police force Hospital 4 so it's unlikely we would be able to go there. We could, if you are worried about her in her house, we can check her address because that's our patch."*

F3: "*Well, I'll give you her name and address now."*

Call Handler *Is that what you want? Do you want us to go to her house?*

8.22 The discussion continued before F3 agreed she would speak to Dale and contact police again if her concerns remained. The call handler did not take F3's details nor Judith's name or address.

8.23 On the 20th February 2021, F3 contacted Dyfed-Powys Police for a second time regarding Judith. She stated that the previous call handler did not take her name or give her a reference number, and passed the following information:

- That Dale told her that Judith was discharged the previous day, but that Hospital 4 had no record of her
- That he previously told people his mother was in Hospital 3.
- That she had spoken to Dale the previous day at 4pm and 6pm and was told firstly that Judith would be home at 6pm and was then told this would be between 8pm and 9pm.
- That upon phoning Dale at 9.30pm, at 9.36am that morning and a third time that afternoon his phone was switched off.

8.24 A THRIVES assessment was carried out and identified a cross referenced incident in January 2021 reported by F1.The officers responding on this

occasion made enquiries with hospitals and attended at Judith's flat where they discover her body.

Analysis

8.25 In terms of the response to the January call the Panel considered this an example of ageism, where the narrative of a younger person is given priority over that of an older person. Dale is considered as a protective factor for Judith by the Police and his account is believed without question over the concerns reported by F1 despite her being forthright and clear in her concerns.

8.26 In January 2021, Dale stated that Judith was there with him in the flat and yet no request is made to speak with her to ascertain her safety and well-being. Dale's account is taken as fact and there is no professional curiosity or challenge in respect of the contradictory accounts that Dale has provided to F1 and the Police in the space of two days or the other concerns reported by F1 e.g. flat windows all being open and Judith's health conditions.

8.27 F1 is still very upset at what she perceives as a lack of action by Police in response to her call. Her assumption was that the Police would at least have spoken to Judith even if they didn't attend at the flat. She is also very angry that her details were not kept anonymous as she had requested and been assured by the call handler.

8.28 The IOPC investigation report confirms that F1 asked to remain anonymous and was told by the call handler that *we never say who informs us.* On reviewing the incident, the IOPC noted that nothing had been recorded on the log to show that F1 wished to remain anonymous and that the officer responding to the call was not therefore aware of this explicit request. Despite the request for anonymity not being recorded on the incident the Panel do not think it is unreasonable that F1's identity would not have been disclosed to Dale.

8.29 The officer stated in respect of their response that

Given that we are currently in a "stay at home" lock down and at that point would have been some five weeks into this present lock down (due to the Coronavirus pandemic) and the rate of cases had been increasing during the weeks prior, it was not proportionate in my opinion to attend at the location and conduct a face to face visit with Judith as due to her respiratory vulnerabilities I felt it would put her at unnecessary risk.

8.30 This account was accepted by the IOPC.

8.31 Whilst accepting that a face-to-face check may have presented a risk to Judith it is the Panel's view that it is not unreasonable for officers to have spoken to Judith to investigate Dale's assertion that Judith was in the house with him at the time and in order to ascertain whether she was safe.

8.32 The IOPC do not identify any learning for Dyfed Powys Police in relation to their responses to the calls for concern for Judith's welfare. It is the Panel's view however that that there are recommendations arising from the handling of this episode.

8.33 In terms of the concerns reported by F3 in February 2021, the IOPC found that the Call Handler hadn't created an incident log for this call and didn't take F3's name. Furthermore, the call handler did not take Judith's name or address and no intelligence checks were carried out or enquires made with Hospitals. If Judith's name and address had been taken this would have flagged up the call for concern made by F1 in January 2021.

8.34 The IOPC also found that the Call Handler placed responsibility on F3 who is in her 80's to make a decision about what she wanted the Police to do when she had clearly stated in her call that she was concerned for Judith's welfare. F3 clearly states in her call that she does not trust Dale and neither did Judith and yet this is not explored at all by the Call Handler in his discussion with F3.

8.35 Dyfed Powys Police guidance for Force Command and Control states *all incidents will be recorded on STORM and will be graded to indicate to Incident Handler / ICAT team the appropriate level of response required.* It further states that they must use the National Decision Model and THRIVES[42] to conduct a risk assessment, grade the incident and determine the appropriate response. The IOPC concludes that as the Call Handler did not open an incident log, it is not possible to determine whether this process had been carried out.

8.36 The IOPC investigation concluded that the Call Handler had a case to answer for misconduct and that, in line with Dyfed Powys Police staff misconduct procedure this could be dealt with by means of a management action from the Head of Department.

8.37 It is the view of the Panel that the reports by F1 and F3 in January and February 2021 identify learning points for Dyfed Powys Police in relation to how concerns for safety are responded to. During the Review the Panel requested an update from the Force in relation to how they ensure a consistent response to calls for concern.

8.38 Dyfed Powys Police has a Policy in respect of Welfare Checks/Safety. This policy relates only to concerns for welfare reported by agencies. In 2018, due

[42] Threat, Harm, Risk, Investigation, Vulnerability, Engagement and Safeguarding assessment

to an increase in demand created by calls for concerns reported by agencies Dyfed Powys Police introduced a script to be used when responding to these calls. This script consists of 12 questions that allows Dyfed Powys Police to better assess the response required.

8.39 All calls for concern are graded using the National Decision Model (NDM) and THRIVES assessment however there is currently no equivalent policy or script for responding to calls reported by members of the public.

8.40 Dyfed Powys Police outlined their intentions to introduce a two-tier response to all calls for concern regardless of the caller, P-Safety and P-Welfare. Using NDM and THRIVES to assess the call, P-Safety would require a priority response to an immediate risk to life or harm. P-Welfare would relate to general welfare checks where subject to a welfare script it would be determined whether it should be police or another agency that attends. This welfare script is proposed for use with calls from the public which will provide Dyfed Powys Police with an opportunity to explore concerns and make an accurate assessment of the response required.

8.41 It is the view of the Panel that there is also learning for the Independent Office for Police Conduct in respect of the findings of this Review.

8.42 There was no contact made with F1 as part of the IOPC investigation. It is the Panel's view that in not interviewing F1 the IOPC did not take her factual account into consideration and were therefore unaware of the impact that the officer's response had on them at the time of the call and subsequently when Dale attended at her home.

8.43 The IOPC did not identify any learning for Dyfed Powys Police. It is the view of the Panel that based on the factual information received as part of the Review that there are recommendations resulting from their responses to calls for concern in January and February 2021 which are set out in the next section.

9. Mid and West Wales Fire and Rescue Service

Overview

9.1 In June 2019, Mid and West Wales attended at Judith's home to conduct a Home Safety Check. This had been requested by Judith who had heard about the checks at a Community Safety talk. During the visit Judith was asked the All Wales Home Fire Safety Checklist questionnaire, a standardised questionnaire that asks a series of questions relating to risk and provides an opportunity for the attending officer to identify any welfare concerns including domestic abuse, hoarding and safeguarding of children/adults.

9.2 Judith responded to the questions stating that she did not drink on a regular basis nor did she take any medication that affected her levels of alertness on

a regular basis. The questionnaire also asked about whether anyone living at the property is experiencing any mental health or mobility issues to which Judith said no.

Analysis

9.3 Having considered the documentation, the Panel noted that the All Wales Home Safety Questionnaire does not include any questions in the Risk Section relating to domestic abuse that could trigger a targeted Ask and Act enquiry.

9.4 By 2019, everyone employed by Mid and West Wales Fire and Rescue Service would have completed Group One of the National Violence against Women, Domestic Abuse and Sexual Violence Training Framework. Group One is intended for all professionals working in the public service. The online training provides:

- basic awareness of what violence against women, domestic abuse and sexual violence is
- how to recognise domestic abuse and sexual violence
- help available to victims.

9.5 Mid and West Wales Fire and Rescue Service reported that they only started to deliver the Ask and Act training in 2021. As explored earlier both Group One and Ask and Act training focuses primarily on interpersonal violence and the Service's representative on the Panel acknowledged that it is unlikely that staff would be as confident identifying older people who were experiencing domestic abuse or those experiencing familial abuse compared to interpersonal violence.

9.6 In the financial year 2021/22 60% of referrals for Home Fire Safety Checks were for individuals over 65 years of age. It is the Panel's view that this identifies a gap in existing workforce development plans relating to older people's experiences of abuse.

10. Pembrokeshire County Council

Overview

10.1 Judith and Dale's contact with Pembrokeshire County Council was primarily with Housing Services but Judith also had contact with Social Services during the timeline of the review.

Social Services

10.2 Judith's contact with Social Services was in relation to Occupational Therapy assessments, the context of which are detailed below.

29/04/2015	Judith self refers to Social Services Occupational Therapy. The referral states that she has mobility difficulties due to severe breathing problems and intends getting a disability scooter. However, outside her warden-controlled property there are several steps and she is asking for a ramp to enable her to get the scooter in and out of the property. It is noted that Judith lives in a ground floor council flat. Adapted bathroom, has pull cord for emergencies. Has had to wait to be back in country for 2 years before applying for PIP. She lived in Cyprus for 6 years due to health reasons.
30/04/2015	Judith is spoken to in relation to her referral. She advises that she is applying for PIP and has not yet bought a scooter. She is advised that if she had Blue Badge and PIP enhanced mobility supplement - DLA Mobility equivalent and letter of intent to buy from scooter supplier, she could go directly to grants. Alternatively, could go on waiting list for OT assessment. Judith states that she will investigate the benefits but would like to go on the Occupational Therapy waiting list.
09/07/2015	County Councillor contacts Social Services on Judith's behalf requesting a new path for level access to the front of her property also needed is a scooter store shed for her mobility scooter. This contact is referred to the Grants Department for assessment/advice
10/07/2015	Social Services note that Judith is already on the Occupational Therapy waiting list and awaiting allocation following the contact from the Councillor on 9/7
03/09/2015	Occupational Therapy visit to Judith's flat. Records note Judith suffers with chronic respiratory conditions, she can be very short of breath on exertion and sometimes too unwell to leave her property. Her condition is expected to deteriorate further in the future, making her more reliant on mobility aids to get about. When she is well enough she goes outdoors using a mobility scooter to gain access to shops etc. Judith lives in a block of sheltered flats and would therefore require a communal ramp to provide level access from her front door to the pavement. Both her and her neighbour both have scooters and are aware that they do not currently meet the criteria for scooter storage. There is concern however that they will continue to store the scooters on the planned pathway, which may not be wide enough for the other to pass. The neighbour also currently parks in front of Judith's property. Recommendation sent to Grants for the identified requirements - no other needs identified.

10.3 Having worked as an assistant social worker, it is clear that Judith is aware of the processes that she is required to go through to have the adaptations done for the ramp in 2015 and again for the scooter store in 2019.

10.4 There is no reference to the work being carried out for a scooter store in the case notes however both F1 and the warden confirm that the store was installed for Judith.

Housing

10.5 Judith's tenancy with Pembrokeshire County Council started in November 2014. Judith's property was classed as Sheltered Housing and as such there was an allocated warden for the property. It is the same warden who has responsibility for the property throughout the duration of Judith's tenancy with an additional warden carrying out duties from May 2019 alongside them.

10.6 Records from 2016 onwards show the warden visiting Judith twice a month for the duration of her tenancy apart from between April and June 2020 when, as a result of Covid, contact is maintained via telephone.

10.7 Housing records show that until 2018 there was a pendant alarm at the flat and also a pull cord alarm in each room. In 2018, a survey of residents about payment for the alarms led to their decommissioning across sheltered housing.

10.8 The warden recalls spending time with Judith in her flat where they would speak about a range of issues including the activities that Judith was involved which are referenced in the records e.g. theology course and craft and jewellery classes. The warden also notes when Judith has had surgery on her foot in 2016 and her recovery.

10.9 The warden further describes Dale as extremely polite and helpful whenever they had contact with him.

10.10 It is noted by the Panel that in March 2017, there is a note on Judith's file stating that Housing staff are *NOT to give the key safe number to her son. This was the key safe for her own use (not the same as the key safe for the communal entrance*).

10.11 In March 2019, Judith applies to transfer from her flat. There is reference in the case notes to Judith reporting noise disturbance from her neighbours in the flat above and the warden confirmed that this was the primary reason for Judith's application for a transfer. This is further confirmed in a letter received in support of the transfer application outlining issues with neighbours which are affecting her mental health. Judith is awarded a medium medical award and assessed as a silver band application. Three months later, in June she

withdraws her application stating that she needed a scooter store and wishes to remain where she is.

10.12 An annual support plan is completed with Judith, the last one in May 2019. The record states;

- *Further assistance – referral made for a gable end gate for the puppy*
- *Safe and Secure – Judith feels safe and secure*
- *Finances – all ok*
- *Social and leisure – All good she has a 5 month old puppy now*
- *Mobility – Mobility has improved and she need to use her scooter so much now (sic)*
- *Care and Support – All ok – Support plan updated*

10.13 On the 30th March 2020, a Covid letter is delivered by the warden and there follows twice monthly telephone contact with Judith until June 2020 when home visits recommence.

10.14 The following table details the contact between wardens, Judith and Dale from August 2020 onwards. Warden 1 is the individual who has been Judith's warden since 2016. Warden 2 carries out visits/contact with Judith from May 2019.

10/08/2020	Visit to Home Address by Warden 2. Record states *Met son outside property, did not meet Judith. No issues reported by Son.*
12/08/2020	Warden 1 *All ok, No issues to report from Judith*
26/08/2020	Warden 2 *All well, no issues reported spoke to the son unsure whether Judith was present*
22/09 and 23/09	No response
05/10/2020	Warden 1 *All ok no problems to report from Judith*
23/10/2020	Warden 1 completed a home visit *All well except for a fall at the weekend. Currently on crutches will be self-isolating for the next two weeks, son helps.*
	Wales enter 2 week firebreak lockdown
26/10/2020	Warden 2 telephone call with Judith *Spoken about extending household – son is looking after her*

09/11/2020	Warden 2 completes a home visit (does not recall seeing Judith on this visit) *Son answered the door, he says she hasn't been well and he does most of the household chores. Updated daily living skills section of the support plan.*
02/12/2020	Warden 1 attempts to call Judith – no reply
14/12/2020	Warden 2 completes a Home Visit *Asthma but otherwise well.* *Warden 2 thinks he saw Judith on this day as no mention of son in the case notes however all that is recorded is that above.
23/12/2020	Warden 1 *Leaflet drop. Whilst delivering in top block son advised his mum had gone to stay with family*
08/01/2021 and 11/01/2021	Warden 2 attempts to call Judith – no reply on either occasion
13/01/2021	Warden 1 sends text messages to Judith *Hi Judith, hope that you are ok.* Reply received from Judith's phone *Hi. Very chesty but being looked after* Warden 1 responds *Good to hear that you are ok Happy New Year.*
14/01/2021	Warden 1 sends a further text enquiring as to whether all is ok
22/01/2021	Warden 1 attempts to ring Judith – no reply
26/01/2021	Warden 1 sends text message to Judith *Hi Judith, are you OK?* No reply
01/02/2021	Warden 1 visits the block of flats to tests the communal alarm. Warden 1 tests the alarm but then has difficulty locking the communal door and running the numbers on the key safe to place the keys back in there. Dale comes out from Judith's flat to the communal entrance door and watches Warden 1 trying to lock the key safe. He said he would do it. Warden 1 asked how Judith was and he said she was in Hospital with Asthma issues. Warden 1 left the property and Dale indicated to them that he had locked the safe.

	It is noted that the key safe referenced in this entry is the communal key safe and not the key safe to Judith's property referenced in the March 2017 entry.
08/02/2021	Warden 1 attends at the property again to test the alarm. It's noted on the system that Judith is still in Hospital. Warden 1 recalls possibly speaking with Dale who came to the communal door in his dressing gown.

10.15 The wardens had not seen Judith since the 23rd October and had not spoken to her since the 26th October.

Analysis

10.16 In terms of responses from Social Services it is the Panel's view that responses to Judith's self-referrals were appropriate with advice and information regarding benefits provided, assessments carried out and onward referrals to the grants department. The requested works were carried out at the property ensuring that it was accessible to Judith when using her scooter.

10.17 In terms of the warden contact the Panel finds that the warden service responded appropriately and line with the requirements of policies and procedures. Like many other services they were persuaded by Dale's plausibility.

10.18 The Panel noted the proactive attempts made by warden 1 to contact Judith from December 2020 to enquire about her well-being. Warden 1 explained to the Chair that this was her practice if she hadn't had recent contact with a tenant. It is the Panel's view that the text response received on the 13th January was sent by Dale from Judith's phone and was an attempt to prevent professionals making more intrusive enquiries about Judith.

10.19 The Panel also noted Warden 1's efforts to support Judith's neighbours following the discovery of her body in February 2021. Warden 1 describes residents being extremely shocked and needing to speak to someone about what had happened and how she had facilitated this.

10.20 During warden 2's home visit on the 9th November, Dale states that Judith hasn't *been well and he does most of the household chores.* Warden 2 updates the daily living skills section of the support plan. This information from Dale may have provided an opportunity for the warden to consider whether Judith had care and support needs requiring assessment in line with the Social Services and Well-Being (Wales) Act 2014[43].Dale's statement that he was doing most of the household chores also provided an opportunity to consider whether he was a carer meeting eligibility for a carer's assessment in accordance with the same legislation.

[43] The Social Services and Well-Being (Wales) Act 2014 provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales https://www.legislation.gov.uk/anaw/2014/4/contents

10.21 A referral for a care and support assessment for Judith would have resulted in contact from social services to assess needs. Based on her diary entries of activity from the 7th November onwards it is the Panel's view that it is unlikely that Judith would have met the threshold for care and support needs however the Panel considered how, if contact had been made in response to a referral it may have provided her with an opportunity to speak with a professional about what was happening and to seek information and advice over the following weeks when Dale's behaviours escalate.

10.22 As employees of Pembrokeshire County Council, wardens are required to complete Group One and Group Two 'Ask and Act' training as part of the Violence against Women, Domestic Abuse and Sexual Violence National Training Framework. Warden 1 confirmed that she has completed the Ask and Act training but that there were no indicators in her contact with Judith that would have triggered a targeted enquiry. Judith only spoke positively about Dale and warden 1's view was that they were each other's support network. Warden 2 stated that they had not completed Group 1 or Ask and Act Training.

10.23 The nature of the warden role means that they have contact predominantly with older people and it is the view of the Panel that bespoke training relating to older people's experiences of abuse should be considered for all relevant roles within Pembrokeshire County Council including wardens, older people's social workers and occupational therapists. This provision, over and above the National Training Framework provision would increase the knowledge, understanding and confidence of staff to identify and respond to older people's experiences of domestic abuse both within an interpersonal and familial setting.

11. Other Issues: Key Lines of Enquiry

11.1 The purpose of this section is to provide further analysis of remaining key lines of enquiry identified in the first part of this report.

Key Line of Enquiry – To consider how older women who are experiencing domestic abuse by an adult child access information and support

The language, imagery and rhetoric about VAWDASV used in publicity campaigns and literature fails to convey the experiences of older people[44]

11.2 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.

[44] 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)

11.3 Friends spoke about perceptions of domestic abuse being between partners rather than family members and how Judith would not have equated Dale's behaviours with the language of 'domestic abuse'.

11.4 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 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 whether these be within interpersonal or wider familial relationships.

11.5 In a 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.*[45]

11.6 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.

11.7 The Regional VAWDASV Partnership is working with survivors across Mid and West Wales to co-design an awareness campaign targeted at older people who are experiencing domestic abuse on where and how to access information and support. This information will be made available in community settings accessed by older people including GP surgeries, pharmacies, libraries, community centres and supermarkets.

11.8 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.

11.9 In the event that Judith had recognised Dale's behaviours as abusive it is the Panel's view that there would have been a number of barriers to her disclosing and seeking help. These barriers may have included;

- Not wanting anyone to think bad of Dale

[45] [45] https://www.olderpeoplewales.com/Libraries/Uploads/Leave_no-one_behind_-_Action_for_an_age-friendly_recovery.sflb.ashx

- Not wanting to be pitied by people as a victim
- Consideration of Dale as her only family and not wanting to lose this relationship despite his behaviours
- Embarrassment – friends have spoken about Judith as a proud person and acknowledging that she was a victim of abuse from her son may have been embarrassing for her
- Loss of face/status – Friends said that status had always been important to her and she may have perceived acknowledgement of the abuse and seeking help as a loss of this status.

11.10 The use of language in respect of routine and targeted enquiries may again have prevented Judith from disclosing Dale's behaviours due to the professional language and terminology used, highlighting again the importance of *how* questions are asked particularly with older people who are more likely to experience abuse from family members.

11.11 The Panel further considered the following elements in respect of the disclosure/identification and appropriate responses to older people experiencing domestic abuse.

Risk Assessment Tool

The standard risk identification tool for domestic abuse used by practitioners including Police, Health and Social Care and the specialist domestic abuse sector is the Domestic Abuse, Stalking and Harassment Risk Indicator Checklist (DASH RIC).

A number of studies[46] have identified the shortfalls in the DASH RIC as it relates to older people's experiences of Domestic Abuse including its focus on interpersonal violence, failings to capture the dynamics of familial abuse or take account of a life-course perspective. These key elements result in risks to older people not being effectively identified or responded to.

There is an adapted version of the DASH RIC for use with older people. The Panel noted that Hywel Dda University Health Board promotes the use of this assessment with older people.

A recent report for the Older People's Commissioner for Wales recommended that *Welsh Government be encouraged to support the use of the adapted risk assessment tool by all organisations responding to VAWDASV in Wales.* The Panel has strengthened this recommendation recognising it as a key element of the system-change that it needed to improve the identification and responses to older people who are experiencing domestic abuse.

Bespoke and specialist support for older people who are experiencing domestic abuse

[46] Sharp-Jeffs and Kelly 2016: Bows, 2019; Chantler 2020

The Older People's Commissioner for Wales report[47]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.

The Panel considered a number of case studies presented by Dewis Choice in respect of older people's experiences of familial abuse and the service model developed to support them in recognising and understanding the abuse they were experiencing.

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. Commissioning of services should be in line with the principles outlined in Welsh Government guidance[48] and the regional service specification developed by the Mid and West Wales Violence against Women, Domestic Abuse and Sexual Violence Partnership.

Training

Whilst relevant authorities are required to complete the relevant elements of the National Training Framework these requirements are currently limited to those identified as relevant authorities e.g. Local Authorities, NHS Trusts and Health Boards and Fire and Rescue Services. It is the Panel's view that there is a need to extend the requirements of the National Training Framework to non-relevant authorities which would include third sector providers including Age Cymru who are working with older people across Wales.

It is also the Panel's view that bespoke training that is tailored to the needs and experiences of older people must be delivered to practitioners across Mid and West Wales:

[47] 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)
[48] https://gov.wales/sites/default/files/publications/2019-05/statutory-guidance-for-the-commissioning-of-vawdasv-services-in-wales.pdf

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[49]

This training, which should be delivered by specialist providers should include exploring the experiences of older people in respect of familial abuse, economic abuse and the link between domestic abuse, dementia and 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.[50]

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[51]

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, isolate or silenced by 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. Learning for the initial sites relating to time and resource commitments as well as what were considered to be prohibitive costs to the programme being 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.

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

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

[51] Finding the Costs of Freedom report, 2014

Five 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[52] 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.

This review has identified that the Ask ANI scheme is operational in pharmacies in Pembrokeshire. The growth of Safe Space initiatives in communities offer opportunities for individuals to access information and support but this review has highlighted the need to ensure that all staff have undertaken the relevant training to respond appropriately to disclosures. Taking the decision to seek help only to receive a negative or unhelpful response may prevent further help seeking behaviours. If organisations such as banks, pharmacies and health and beauty businesses are proactively promoting Safe Spaces the VAWDASV Board require assurances that these are operating safely.

Key Line of Enquiry – To consider whether, and to what extent Mental Health and/or Substance Misuse contributed to the circumstances leading to Judith's death.

Substance Misuse

11.12 There is a significant amount of evidence about Dale's misuse of substances (prescribed and illicit) which have been referred to above and are summarised below:

- Recollections of ex partners of his drug use;
- Dale's admission to the pharmacist that he was using cannabis to supplement his prescription medication;
- Judith's diary entries where it seems that she was buying the cannabis for him and refers to it as 'baccy';
- Dale's Grindr messages to his ex-partner in December 2020 says that he *Got nicely dmt'd for my bday. (*Dimenthyltryptamine (DMT) is a hallucinogenic drug that can be smoked or snorted and is known for giving users a very intense 'trip');
- Use of prescribed controlled drugs for chronic back pain prior to the timeline for the review including Oromorph, Morphine and Diazepam;
- His frequent requests for his prescribed (controlled drug) medications earlier than they were due reporting that he was working away or was going on holiday;
- Reporting to the Chronic Pain Clinic in 2017 that he is addicted to Diazepam;

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

- Three occasions where the GP places Dale on daily prescriptions. Two of these occasions follow Dale's admission that he had lost control of his medication;
- Between September and November 2017 Dale presents at the Out of Hours GP on four separate occasions requesting pain medication and is prescribed Pregabalin; The third and fourth presentation at Out of Hours were during a period when he was on daily prescriptions from the GP for pain medication;
- In September 2019, the pharmacy reports to the GP that Dale has presented with prescriptions that have been altered to receive his medication earlier;
- The theft of Judith's Gabapentin in 2017 and 2020 and his continuing to pick up the prescription after her death, providing him with an additional source of controlled medication alongside his own

11.13 Dale's prescribed medication would have a depressive impact on the central nervous system, reducing pain and leading to a sense of sedation. When combined with his use of cannabis this is likely to have increased the sedation resulting not only in pain relief but also an element of pleasure/relaxation.

11.14 Despite the GP's recognition of the dependency and attempts to manage the use of prescribed medication, Dale would substitute prescribed drugs not only with illicit drugs but also Judith's prescribed (controlled) medication.

11.15 It is the view of the Panel that Dale used a variety of substances, prescribed and illicit, and some in a dependent way initially to manage his pain but also for the pleasurable effects. The Panel further considered that he used these substances to escape the reality of his day-to-day life – he had no job, no income and no friends that the Panel were able to identify.

11.16 Judith discovering that he had stolen her medication and the withholding of her prescription when she was in pain are, in the Panel's view, significant factors in the circumstances of her murder.

Mental Health

11.17 There are three relevant contacts with agencies which reference Dale's mental health:

- 2011 intentional overdose of insulin and his stated intention of wanting to end his life;
- Reported *low mood* to the chronic pain service in 2016;
- 2017 his description of himself as feeling *increasingly isolated* quoted in a letter sent from the Chronic Pain Service to Dale's GP.

11.18 There is no evidence that Dale contacted his GP for a referral to Community Mental Health Services following the assessment by the Crisis Intervention Team in 2011 and there is no record of a referral from the Chronic Pain Service to the Primary Mental Health Service in 2016/17. It is the Panel's view that whilst there is evidence of poor mental health there are no referrals to services.

11.19 The Panel also considered his wider behaviours and what they may indicate about his mental health. Dale's history of compulsive, plausible lying can be seen throughout the chronology and Judith references these as one of her main concerns in the letter she writes to the GP in January 2017. The timing of this letter is significant as it is after the assessment at the Chronic Pain Service but before the GP receives the letter from this assessment. It is the Panel's view that consideration of the concerns raised in this letter, its timing and the fact that it was not discussed further with either Dale or Judith present missed opportunities to respond to Dale's mental health.

11.20 The Panel also considered Dale's behaviour following his murder of Judith. Dale continued to live in Judith's flat following her murder and up until the time of his arrest with her body in the bedroom the whole time. Judith was found with a plastic bag tied around her neck in what the Police believe to have been an attempt to prevent any further mess following the attack that led to her death. Dale had made no attempt to clean the blood in the bedroom, just closed the door and continued to live in the remaining rooms of the flat. Police described the flat as filthy when they attended with dishes and rubbish covering all surfaces in the kitchen and bathroom. Having heard how meticulous Judith kept her flat this was in stark contrast to how Judith had lived.

11.21 As part of his defence, Dale's legal team requested a psychological report. The Chair requested a copy of this which was declined.

11.22 It is the Panel's view that in general terms that Dale's poor mental health, his history of substances misuse and his abusive behavioural patterns were all contributing factors in the period leading up to Judith's death. They are certainly influential factors in Judith and Dale's relationship over a long period.

Key Line of Enquiry: To examine the impact of Covid-19 on the daily lives of Judith and Dale, the ability to access information and support and agency responses

11.23 The table below summarises the Welsh Government response to the Coronavirus Pandemic as relevant to the timeline of this review.

Date	Decision/Restrictions
23rd March 2020	Full 'stay at home' lockdown directed which lasts until 1st June 2002
1st June	Two households allowed to meet outdoors maintaining a two-meter social distance
22nd June	Non-essential retail allowed to re-open
6th July	Two households in Wales could form an 'extended household' enabling them to meet up indoors and stay overnight
16th August	People shielding in Wales no longer need to do so and four households could form an extended bubble and meet indoors
September	The number of cases start to increase and measures are re-introduced including meeting of more than 6 people banned
23rd October	A two-week *short sharp firebreak* lockdown introduced in Wales during which pubs, restaurants and hotels close and people told to stay at home
9th November	End of firebreak. Two households allowed to form a support bubble and four people from different households allowed to meet in bars, pubs and restaurants
December 2020	Covid cases rise again and further restrictions introduced in pubs, restaurants and cafes from 4th December
16th December	Welsh Government announce only two households and a single person living alone permitted to meet between 23rd and 27th December
19th December	New lockdown comes into force with the exception of Christmas Day only
29th January 2021	Lockdown extended for a further 3 weeks. Two people from different households can meet outdoors
19th February	Lockdown extended for a further 3 weeks.

11.24 *Covid scared us, frightened us and disrupted our routines* is how one of Judith's friends described the impact of covid on the lives of older people.

11.25 Whilst Judith lived with a number of health conditions including Chronic Obstructive Pulmonary Disease (COPD) and asthma she was not required to shield in line with Welsh Government guidelines. The restrictions however undoubtedly increased her vulnerability and one of her friends said the following about the impact it had on her

She struggled during Covid with the loss of social networks and activities

11.26 Hearing from friends how much Judith enjoyed being with people and her weekly routines of Church, Choir and Social Club helped the Panel understand how isolating the period of Covid lockdowns and restrictions were for Judith.

11.27 When restrictions were eased Judith would meet with a friend to walk Ruby and friends describe how, throughout lockdowns Judith kept in touch via telephone and online messaging. F2 met with Judith for lunch on the 8th October before the firebreak lockdown and this was the last time she saw her best friend.

11.28 Friends spoke about how Covid had hidden people away and they recognised how they had *stuck to the rules* throughout lockdown period. In the period December 2020 to January 2021 when friends began to worry about Judith, they spoke about how Wales was in a Level 4 lockdown, and they didn't feel they could go and check on her.

11.29 Friends also recognised how Dale was able to use Covid as a smokescreen after he had killed his mother, beginning in December 2020. *Covid gave him excuses and we weren't in a position to challenge him* is how one friend describes that period when they were concerned about Judith and Dale was providing plausible explanations for her absence. Furthermore, Dale was able to use Covid to hoodwink agency responses to concerns for Judith.

11.30 The Reverend of Judith's Church explained that pre-Covid she would have visited any parishioner who was in hospital within 48 hours of their admission. Covid prevented her from doing this with Judith.

11.31 Friends consistently spoke about the fact had it not been for Covid, Dale's lies would have been found out sooner, the community would have known Judith was missing sooner and the alarm for her safety would have been raised earlier.

11.32 Both Judith's friends and the Panel recognised that the circumstances of Judith's fall and the firebreak lockdown in October 2020 allowed Dale into Judith's home and pushed them into each other's company. It is possible that Judith felt increasingly vulnerable at this time, having fallen, experiencing pain and the new lockdown and this may have resulted in her feeling that she needed Dale more at this time to walk Ruby, collect her medication and assist her in the house. This resulted in Dale having greater power and control in the relationship as Judith's vulnerability and dependency on him increased. This feeling of power and opportunity gave Dale a sense of entitlement to steal money and medication from Judith during this time.

11.33 It is the Panel's view that without doubt, Covid, Judith's physical and emotional vulnerability and Dale moving in with her provided a change in circumstances which, combined with the theft of her medication and money, facilitated the context in which her murder took place.

Key Line of Enquiry: To consider the experiences of Judith's friends and family and examine where/how they could access information and support

11.34 The Panel considered the experiences of Judith's friends of accessing information and support. From speaking directly with friends and considering the information from Dyfed Powys Police and the IOPC it is clear that they cared for Judith and were worried for her.

11.35 They knew Judith best and knew that something wasn't right. They were resourceful in attempting to ascertain where Judith was, talking with each other, going to her flat and persistently contacting Dale asking about Judith's health. They made their own enquiries with Adult Social Care and Hospitals and only when they had exhausted these enquiries and felt they had further evidence to substantiate their concerns did they contact Dyfed Powys Police in January and February 2021.

11.36 It is the Panel's views that concerns raised by community members and friends to bring matters to the attention of services should be responded to with equal importance as concerns raised by agencies. They know the individual best and may have valuable intelligence in respect of the context and nature of their concerns.

11.37 Friends were consistent in their view that Judith wouldn't have seen herself as a victim of domestic abuse and neither did they recognise Dale's behaviours as such. This further highlights the need for greater awareness and understanding amongst communities of older people's experiences of domestic abuse and familial abuse specifically so that friends and family members can recognise and seek information about how best to speak to and support someone who may be experiencing abuse.

SECTION FIVE – RECOMMENDATIONS

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

Single Agency Recommendations

Hywel Dda University Health Board

- 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
- Corporate Safeguarding Team to audit the embedding of the Hywel Dda University Health Board's Ask and Act Policy and report to the Strategic Safeguarding Working Group
- Ask and Act training to be reviewed and elements relating to Older People's experiences of abuse to be included
- Lead VAWDASV and Safeguarding Practitioner to work with primary care to strengthen links with local specialist domestic abuse services
- Information relating to the Ask Ani Scheme to be sent to all Pharmacies in the Health Board to encourage uptake of this safe space initiative
- The Clinical Director/ Deputy Associate Medical Director, Primary and Community Care Services to discuss the process for reporting altered prescriptions with the Health Board Medicines Management Team to ensure all services are clear on their responsibility to report such concerns.

Dyfed Powys Police

- Dyfed Powys Police to brief all staff that caller details should remain anonymous and should not be disclosed. Where callers specifically request anonymity call handlers must include this on the incident log this to ensure that identities are not revealed
- Where there are concerns for adults identified as vulnerable Dyfed Powys Police should, as a minimum, speak to the individual in person or on the telephone to ascertain their safety before closing the incident
- Dyfed Powys Police to provide a timeline for the implementation of the new approach to responding for calls for concern and outline how this process will be embedded and monitored as daily business

Mid and West Wales Fire Service

- The All Wales Home Safety Questionnaire to be revised to include questions that may indicate domestic abuse and that will lead to Ask and Act enquiry

- All Mid and West Wales Fire and Rescue staff identified to receive Group 2 training in line with the National Training Framework also to receive bespoke training relating to older people and domestic abuse

Pembrokeshire County Council

- Provide a compliance report of staff who have completed Group 1 and Group 2 of the National Violence against Women, Domestic Abuse and Sexual Violence Training Framework
- Provide an implementation plan to meet remaining requirements relating to Group 2
- Commission bespoke training on the experiences of older people of domestic abuse to be delivered to all frontline practitioners who have been identified for Group 2 training
- Commission a service/services that can provide a bespoke, tailored service to respond to the needs of older people who are experiencing domestic abuse

Regional Violence against Women, Domestic Abuse and Sexual Violence Partnership

- Community based Safe Spaces schemes to be included in regional Safeguarding and Violence against Women, Domestic Abuse and Sexual Violence raising awareness campaigns
- 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
- Develop a Quality Assurance Framework for Safe Space initiatives operating in the region to ensure that individuals accessing these spaces are safe and safeguarded.

Health Education and Improvement Wales

- Training provided to Pharmacists by Health Education and Improvement Wales to be revised and updated to ensure that it is consistent with Welsh Government's Violence against Women, Domestic Abuse and Sexual Violence National Training Framework

Welsh Government

- 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 Pharmacies
- Provide a timeline for the expansion of National Training Framework provision, in particular Ask and Act to non-relevant authorities
- Support the use of the adapted risk assessment tool for older people experiencing domestic abuse by all organisations responding to VAWDASV in Wales
- IRIS to be mandated across all GP practices in Wales and resourced by Welsh Government in line with its commitments to early intervention and prevention in the National Violence against Women Domestic Abuse and Sexual Violence Strategy

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
- Independent Office for Police Conduct to detail how learning from this review will inform national practice