SAFER PEMBROKESHIRE

PEMBROKESHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

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.

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SECTION ONE – THE REVIEW PROCESS

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. 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.

3. Terms of Reference

3.1 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.

3.2 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.

4. Contributors to the Review

4.1 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.

4.2 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	

4.3 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 but no information was received from wither organisation.

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

4.5 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.

5. Review Panel Members

5.1 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.

5.2 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.

5.3 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.

5.4 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.

5.5 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.

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

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

5.8 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.

6. Appointment of an Independent Chair /Author

6.1 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'.

6.2 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.

6.3 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.

6.4 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.

6.5 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.

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

6.7 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.

SECTION TWO – SUMMARY CHRONOLOGY

7. Summary Chronology

7.1 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.

7.2 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.

7.3 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 THREE – KEY ISSUES ARISING FROM THE REVIEW AND LESSONS LEARNED

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

8.1 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. It concludes that Dale's profile and patterns of behaviour have commonality with the findings of the research[1] in respect of mental health and substance misuse, criminal behaviour, financial issues and dynamics of care.

8.2 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.

8.3 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.

8.4 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.

8.5 His power and control further increases when, following Judith's fall in October 2020, he moves into her flat and she is dependent upon him to do household tasks and look after the dog. The Covid firebreak at the end of October 2020 further increases Judith's isolation as friends are unable to visit her.

8.6 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.

8.7 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

[1] 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, DOI: 10.1332/239868021X16316184865237

this point more than any other Dale holds the power and control in the relationship with Judith.

8.8 It is the view of the panel that Judith's vulnerability at this time and the opportunities afforded to Dale by moving in with Judith significantly intensified the abusive and controlling dynamic of their relationship resulting in a significant step change and an escalation in Dale's behaviours.

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

8.10 It is the Panel's belief that Dale's response to being confronted by Judith for his lies has been to kill her.

9. Agency Involvement with Judith and Dale

Health involvement: Judith

9.1 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.

9.2 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.

9.3 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.

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

9.5 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. Judith's response was recorded as no all three occasions.

Lessons Learned

- 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.

- 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.

- 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.

- 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.

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

- 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.

<u>Health Involvement: Dale</u>

9.6 The information considered by the Panel indicates that Dale had a complex medical history over a long period of time including:

- A suicide attempt;
- Overuse of prescribed medication;
- Lies and deception in order to gain access to further medication;
- An admission to the chronic pain service that he was not coping.

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

Primary Care

9.7 Dale had frequent contact with Primary Care services. He 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.

9.8 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.

9.9 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.

9.10 Judith wrote to Dale's GP in January 2017 to highlight her concerns about his behaviours. It is the Panel's view that Judith considered the GP a trusted professional, someone impartial and authoritative who she believed could help Dale.

9.11 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.

9.12 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.

Pharmacy

9.13 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.

9.14 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.

9.15 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.

9.16 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.

Chronic Pain Clinic

9.17 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.

9.18 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.

Lessons Learned

- In relation to the letter sent by Judith to the GP in 2017, 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.

- 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.

- 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.

- 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.

<u>Dyfed Powys Police</u>

9.19 This section examines the response of Dyfed Powys Police to an incident reported by Judith in June 2001 whereby Dale receives an Adult Caution for offences of Theft from a dwelling and 3 counts of obtaining property by deception and responses to concerns raised by Judith's friends in January and February 2021.

9.20 In terms of the response to the call made by F1 in January 2021 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.

9.21 When speaking to the Police on the occasion 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.

9.22 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.

9.23 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.

9.24 Whilst accepting that a face-to-face welfare check may have presented a risk to Judith due to covid and her health related vulnerabilities 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.

9.25 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 in relation to how concerns for safety are responded to by Dyfed Powys Police.

<u>Mid and West Wales Fire Service</u>

9.26 In June 2019, Mid and West Wales attended at Judith's home to conduct a Home Safety Check. 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 enquiry.

Learning

- Mid and West Wales Fire and Rescue Service reported that they only started to deliver the Ask and Act training in 2021. 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.

- 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.

Pembrokeshire County Council

9.27 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.

9.28 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.

9.29 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.

Learning

- 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.

10. Key Lines of Enquiry

To consider how older women who are experiencing domestic abuse by an adult child access information and support

10.1 It is the Panel's view that 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.

10.2 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'.

10.3 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.

10.4 The Panel examined the following elements in respect of improving responses to the disclosure/identification of older people experiencing domestic abuse and made recommendations as appropriate;

- Risk Assessment Tools
- Bespoke and specialist support
- Training
- Community based responses

The impact of Covid-19 on the daily lives of Judith and Dale, the ability to access information and support and agency responses

10.5 *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. Whilst Judith was not required to shield the restrictions imposed 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

10.6 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.

10.7 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.

10.8 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.

10.9 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.

The experiences of Judith's friends and family and examine where/how they could access information and support

10.10 The Panel considered the experiences of Judith's friends of accessing information and support.

10.11 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.

10.12 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.

Lessons Learned

- 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.

- 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 FOUR – 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 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