SAFER PEMBROKESHIRE

PEMBROKESHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

DEATH OF JUNE IN FEBRUARY 2021

Rhian Bowen-Davies Independent Chair and Author

February 2022

A note to June's Family

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

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

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

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

Contents

1. Introduction

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

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

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

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

2. Circumstances of the Review

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

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

The letter within the envelope written and signed by Peter read

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

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

12/8/2019	Dental appointment – examination, radiographs and fillings	Dental appointment – fillings and extraction
2/9/2019	Recall for seasonal flu vaccination	Recall for seasonal flu vaccination
13/9/2019	Authorisation to give flu vaccination	
19/9/2019	Invitation for flu vaccine sent via text message	Invitation for flu vaccine sent via text message
8/10/2019		Invitation for flu vaccine sent via text message
14/10/2019	Recall for shingles vaccination	Recall for shingles vaccination
22/11/2019	Invitation for flu vaccine sent via text message	Invitation for flu vaccine sent via text message
19/2/2020	Dental appointment – standard recall for examination. June reported that she couldn't get used to the denture. Option of having another made – would like to think about it	Dental appointment - examination
24/2/2020	Seasonal influenza vaccination declines not responded to x3 text messages	
3/3/2020		3rd SMS text message sent for influenza vaccine
3		
10/3/2020	No response to bowel cancer screening programme invitation. This is a screening message – NO ACTION REQUIRED	
18/3/2020		Incoming call from daughter 1 to Peter's mobile at 10.44hrs – lasted 19minutes 52 seconds Text exchange between Peter's phone and Daughter2 relating to shopping channel (4 texts in total between 11.30hrs and 12.45hrs)
24/3/2020		Text from Peter's phone to Daughter 2 at 14.44hrs *Hi. Card came in post. Dad xxxxx* *Mother's Day was 22nd March 2020
23rd March 2020	National Lockdown in response to Covid 19 Pandemic – 'Stay at Home' requirement and closure of all non-essential retail and hospitality	
5/4/2020		Attended Emergency Department tent (tent outside ED to assess patients and treat where appropriate to avoid

		admission due to Covid – 19 risks) Complained of sore mouth. Saw dentist 8 months ago – extraction 2 months ago – nil done. c/o diffuse pain: lower jaw incisors and right side. Taken Paracetamol x 2 doses daily. Past medical history nil significant. Drug history – nil. On exam – nil obvious see apart from very caries teeth. 1 very small rubbery tender lymph nose right anterior cervical region. Advised patient I am not a dentist; not qualified to treat dental issues; would not normally treat this but due to current crisis I will. Advised him to contact his own dentist first thing in the morning. For Amoxycillin 500mgs tds for 7 days
6/4/2020		Contacted dentist – clinical advice given
8/5/2020	Covid restrictions in Wales extended for a further 3 weeks	
29/5/2020	'Stay at Home' message changed to 'Stay Local' in Wales. Two households can meet outdoors with social distancing.	
22/6/2020	Non-essential retail reopens. Sta Local message continues in Wales.	
6//7/2020	Stay Local message in Wales is lifted	
6/7/2020	Pneumococcal vaccination invitation SMS text message sent	Pneumococcal vaccination invitation SMS text message sent
23/7/2020	Administration of shingles vaccine	
3/8/2020	Further lifting of Covid restrictions in Wales	
22/8/2020	Further lifting of lockdown restrictions in Wales	
24/9/2020	Authorisation for seasonal flu vaccination	Authorisation for seasonal flu vaccination
6/10/2020	Invitation for flu vaccine sent via text message	Invitation for flu vaccine sent via text message
13/10/2020	Authorisation for pneumococcal vaccination	
23/10 – 9/11 2020	Circuit Breaker introduced in Wales in response to increase in Covid cases. Stay at Home message introduced and hospitality and non-essential retail closed.	
23/10/2020		FGP records a failed encounter – message left on answer machine. Tried to ring to offer flu vaccine. Text message sent out. Please contact GP Surgery
27/10/2020	GP practice received letter from patients.	

	Please delete 07415602038 from your records as this phone is no longer in use. This property is rented and has no BT phone line. It is in a POOR RECEPTION mobile phone area. So any use of a mobile can only be some distance away from us. It is not the best of situations but being on Benefits it is all we can presently afford. Should it be essential to contact us perhaps writing a letter is the only option. Many thanks Signed by both Peter and June	
30/10/2020	SMS text message sent to patient	SMS text message sent to patient
3/11/2020	Declined consent for short message service texting	Declined consent for short message service texting
5/11/2020		Text message sent from Peter's phone to daughter 2 at 14.45hrs *Mum dad very well. Essential shops always open. Car good Love to all xxx*
20/11/2020		Text message to Peter's phone from Daughter 2 at 14.54hrs *Hi dad/mum. How you both doing? I hope you are keeping well. Would be nice to chat to you so let me know when's good over the weekend. Love xx*
19/12/2020	Level 4 Covid Restrictions re-introduced in Wales including 'Stay at Home' and closure of all non-essential retail/hospitality. These restrictions were still in place at the time of deaths in February 2021.	
24/12/2020	Text message to June's phone from Daughter 2 at 11.13hrs *A huge thank you for your beautiful Christmas card and money. The girls eyes lit up, it was very kind of you both. How are you keeping? With this virus and rainy weather its been miserable. I hope you are both well. I had planned to send you a lovely package but with main shops opening/closing I've not been that organised. I'm sorry but you will have something belated. I've even warned the girls that gifts are a bot light this year……All is good and we are keeping well so that's the important thing. I've tried calling you today. It would be wonderful chatting to you both*	Text message to Peter's phone from Daughter 2 at 11.13hrs *Morning mum and dad. I must apologise. I have changed my phone provider and may have sent text to an old number stored in my contacts.* *A huge thank you for your beautiful Christmas card and money. The girls eyes lit up, it was very kind of you both. How are you keeping? With this virus and rainy weather its been miserable. I hope you are both well. I had planned to send you a lovely package but with main shops opening/closing I've not been that organised. I'm sorry but you will have something*

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

	Too much pain	
16/1/2021	Records in diary *Want to die soon*	
17/1/2021	Records in diary *Last beautiful journey round Gwaun valley*	
19/1/2021	Records in diary *Too much pain*	Text message to Peter's phone from Daughter 2 *Hi Dad. Tried calling a few times. Hope you and mum are keeping fit and well. All fine with us. Love xxx*
20/1/2021	Records in diary *Let me die*	
21/1/2021		Text from Peter's phone to Daughter 2 *Tbx for text both well. My fone says it cannot accept your dvd. Ours is old two g gsm. Love mum to all xxx*
26/1/2021	Record in diary *Anniversary*	Failed encounter x2. No answer when tried to contact re COVID vaccine.
26/1/2021		Missed call from Health Centre – no message left.
29/1/2021	Record in diary *Son 1*	Failed encounter No answer when tried to contact re COVID vaccine. Message left on answer phone.
2/2/2021	Authorisation for COVID 19 vaccination	
3/2/2021	Covid vaccine – refusal to start or complete the course	Covid vaccine – refusal to start or complete the course
4/2/2021		6 calls made from Peter's mobile to Pembrokeshire County Council Waste Team 09.46hrs Answered and lasts 1 minute 12 seconds 09.54 hrs Not answered 09.55hrs Answered and lasts 1 minute 26 seconds *this was an incoming call 12.42hrs Not answered 12.44hrs Answered and lasts 2 minutes 11 seconds 13.21hrs Answered and lasts 1 minute 37 seconds
7/2/2021		Text message to Peter's phone at 15.07hrs from the Property Surveyor asking Peter to let him know available dates for the survey to be conducted.

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

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

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

8. Key Issues arising from the Review

June and how she lived her life

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

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

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

8.4 The Panel note that it appears to have been a whirlwind relationship before June and Peter marry. Whilst this was 50 years ago this commitment 'whirlwind' is identified by Professor Jane Monckton Smith as a stage of the Homicide Timeline; relationships developing very quickly with the aim of being able to secure a commitment.[1]

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

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

8.7 It appears that June and Peter led very isolated lives, both from their families and society. Their children had never visited the cottage in the time they were tenants and it does not appear that they had any visitors during the eight years of their tenancy.

8.8 As a couple they were fundamentally self-sufficient, not relying on anyone else and declining offers of help from a neighbour during the national lockdowns. It is the Panel's view however that this self-sufficiency was used by Peter as a means

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

of control and the creation of extreme dependency on him by June. It is Peter who does all of the engagement with the outside world; letters, phone calls, interaction at the Post Office, supermarkets and with agencies.

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

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

8.10 It is the Panel's view that Peter created a version of reality as a way of exercising control over June; a reality where he is riling against what the world has become, how it's them against the world and how everyone is failing them.

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

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

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

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

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

8.16 Living with control is described by Professor Jane Monckton Smith as Stage 3 of the Homicide Timeline. She speaks of a 'web of control' that can last a lifetime

if there are no challenges to this control or triggers that escalate the behaviour of the abuser[2].

<u>Line of Inquiry 2</u>: To identify which agencies/organisations had involvement with June and Peter in the timeline for the review consider the appropriateness of responses and any services provided and <u>Line of Enquiry 3</u>: Opportunities to identify and respond to domestic abuse

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

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

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

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

- June attended at the **Emergency Department** twice during the timeline: The first in **October 2015** when she presented with swelling to her left jaw and following an assessment was transferred to Swansea for surgery where she remained for 2 days. The second was in **May 2016**, when she attends at the Emergency Department having fallen in the cottage and injuring her left elbow. During her attendance at the Emergency Department in May 2016 a routine domestic abuse enquiry is undertaken and a negative response is noted on her record. June is not identified as a vulnerable person or being at risk of abuse or neglect. June is admitted to hospital and has surgery to her

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

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

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

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

8.21 The Dentist was the primary care service that the couple regularly attended for preventative and acute treatment. This contrasts with engagement with GP where there is a pattern of non-attendance for preventative health care screening/vaccinations however medical attention is sought for episodes of acute pain with the exception of June's fall in January 2021.

8.22 It is the Panel's view that attendance at the Dentist may have been seen by Peter as non-authoritative/threatening compared to the GP who may have been considered an authority figure who may have asked questions and intervened. The Panel concluded that Dental Practices provide an opportunity for identification and disclosure by individuals who may not access or feel comfortable in more formal health settings and the establishment of DRiDVA, a

model of the IRIS project in Dental Practices in England was noted by the Panel.[3]

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

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

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

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

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

8.24 In response to the Covid pandemic the world was operating in a way that was far removed from what Peter was comfortable with and one which he felt he had control. When referring to his medical notes in 1995 it states that Peter had issues with power and control and in particular the sense of others having control

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

over him. It is the Panel's view that the changes to everyday life enforced by Covid left Peter feeling out of both his comfort zone and control and that this sense of a loss of control may have resulted in a deterioration in Peter's mental health.

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

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

8.27 The Panel note however that regardless of whether there was a deterioration in Peter's mental health June's murder was meticulously planned. Peter had written and posted letters to the Sorting Office including detailed directions to the property. He had provided written notice to the Property Management Company and left detailed instructions to Police who attended the property in relation to who to notify of their deaths and funeral plans. The planning of and carrying out the homicide are the final stages of the Homicide Timeline.[4]

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

8.28 When the first national lockdown in response to Covid 19 was announced in March 2020, Local Authorities, Health and other services were driven to implement changes to service delivery models overnight which led to an acceleration in the digitalisation of information and access to services. For both GP and Dental Practices there is learning in relation to the accessibility of information, much of which went online. Given the age profile in Pembrokeshire there was the potential for this approach to exclude some groups of people

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

including older people, those who are economically disadvantaged and those with limited or no digital access. The Older People's Commissioner for Wales report *Leave No-one Behind* (2020)[5], concludes that it is possible there were assumptions that people would know that health services were available to access during the pandemic.

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

Housing – Suitability and Location

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

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

9. Concluding Remarks

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

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

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

10. Lessons to be Learned

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

10.2 Single Agency

Hywel Dda University Health Board

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

Welsh Ambulance Service NHS Trust

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

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

Dyfed Powys Police

- The Family Liaison Officer assigned to this case had no prior involvement with Domestic Homicide Reviews and hadn't received any training or information relating to DHRs. Before the Chair's meeting with the Family Liaison Officer in May 2021 the family had not been provided with any information relating to the review. Whilst the Liaison Officer facilitated initial contact with family members it is the Chair's view that the Liaison Officer having an awareness

and understanding of the DHR process would have resulted in the family being aware of the review process at an earlier point in the investigation. An understanding of the statutory nature of the review may also have assisted the Liaison Officer in recognising the aims and purpose of the review.

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

10.3 Regional and National

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

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

11. Recommendations

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

11.2 Single Agency Recommendations

Hywel Dda University Health Board

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

Dyfed Powys Police

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

Welsh Ambulance Service NHS Trust

- Learning from this IMR be shared within the organisation to support the understanding of
    - Expected practice as it relates to the health and social care considerations of all patients and service users and
    - The principles of Social Services and WellBeing (Wales) Act 2014 and Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 within the Welsh Ambulance Service Trust
- The Safeguarding Team to audit the embedding of the WAST Ask and Act Policy in practice and report to the relevant Strategic Safeguarding Group

Pembrokeshire County Council

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

11.3 Recommendations for the Regional VAWDASV Board

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

11.4 Recommendation for the Chair

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

11.5 National Recommendations

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

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

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