Dorset Community Partnership

Domestic Homicide Review

Daisy died in April 2021

Executive Summary

Chair and Author Katie Bielec

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**Foreword – Daisy’s children**

*We all knew her, we all love her, she influenced all of our lives positively, in one way or another. She was a daughter, a mum, a nanny, a wife, an in-law and a friend. She had a passion for life, a wicked sense of humour and an infectious laugh which endeared her to everyone she came into contact with. It is a great testament to her nature that she formed so many long-lasting friendships over the years. By which name you knew her, whatever role she had in your lives, whether you knew her briefly, or a time that stretched through the years, always we honour and remember her for the kind, vibrant and beautiful woman she was.*

*Her greatest joy was being surrounded by her family and friends; we overcame many challenges together, but somehow everything worked out. It worked because we were not alone. We had each other. Our cohesion allowed us to master constant change and meet trials head on. It gives us an unassailable power; this power persists with us today.*

*She had five children of whom she loved with every ounce of her being. She told us that we were her greatest achievements in life and showed this in her dedication to ensuring our happiness. Whatever she was doing, at any time of the day or night she never turned down an opportunity to spend time with those she loved. Her devotion to her children had no limits, she went above and beyond to ensure their happiness and we are thankful to have such a wonderful mum who instilled in us, her children, the values of kindness, compassion, selflessness and loyalty.*

*She listened without judgement. She gave without expectation. She helped out because it was the right thing to do. Her passion for providing care for others was reflected in her choice of career, she brought this same compassion each and every day she worked as a healthcare assistant. She was a nurturing, sensitive and warm-hearted individual who loved her family and friends deeply. She truly had a tender heart.*

*“You are my sunshine, my only sunshine. You make me happy when skies are grey. You'll never know, dear, how much I love you. Please don't take my sunshine away.”*

*Throughout our lives, she reiterated one thing: her absolute and unshakable faith in us. No matter the endeavour she believed in us. She never questioned the things that we wanted or decided to do. She trusted and believed we would make the right decision and accomplish anything we set our mind to. By putting her faith and trust in us, she cultivated in us the belief that we could do anything. Her every move created the certainty that drives us today; Believe. You'd be surprised how far this belief can go.*

*She was also blessed with four grandchildren, of whom never wanted for anything. Her generosity was endless in her love, she sacrificed time, money, sleep and even holidays! We are especially grateful for all of her support, she was always willing to babysit or go to the park, she loved treating them, and much to our annoyance, forever buying them sweets! Her grandchildren are going to miss her deeply, but will remember her fondly and love her always.*

*There's a saying, which goes: "Nothing is so strong as gentleness, and nothing is so gentle as real strength". That saying could have been written especially for our mum. Her love and devotion for her family did not require words because it was in every single thing she did, and that's absolute love. She shared our worries, was our shelter when things got tough and her constant love and reassuring presence made us feel that we could get through anything that life might have thrown at us.*

*This lesson and many more are the memories that each of us will keep in our hearts. So, mum, from you we learnt to be wise in words, actions, thoughts and deeds. You leave to this life, your family, your most treasured possession. And through your family you will live forever in our hearts:*

*“My Mother kept a garden. A garden of the heart; She planted all the good things, that gave my life it's start.*

*She turned me to the sunshine, and encouraged me to dream: Fostering and nurturing the seeds of self-esteem.*

*And when the winds and rains came, she protected me enough; But not too much, she knew I'd need to stand up strong and tough.*

*Her constant good example, always taught me right from wrong; Markers for my pathway to last my whole life long.*

*I am my mother’s garden; I am her legacy. And I hope today she feels the love, reflected back from me.”*

# **Introduction**

1. Dorset Community Safety Partnership (CSP), the independent chair and panel members want to offer their deepest sympathy and condolences to Daisy’s family and friends. The review has been enriched with the information provided and memories shared by the family. They provided an insight of the woman Daisy was as Mother, Grandmother, Daughter, friend and colleague. The chair would also like to thank all those who contributed to the review for their honesty, time, reflection and support.
2. This summary outlines the findings within the Overview Report.
3. In line with Home Office Statutory Multi-Agency Guidance[[1]](#footnote-1) paragraph 75, in order to protect the identity of all those personally involved within the review and to comply with the Data Protection Act 1998 pseudonyms have been used, all names were chosen by Daisy’s family.
4. Daisy was murdered by Robert at the beginning of April 2021, Robert subsequently took his own life later that day. Dorset Police informed Dorset CSP a few days later. Due to Daisy and Robert previously being in an intimate relationship and with further information provided, Dorset CSP agreed to conduct a Domestic Homicide Review (DHR). The Home Office was informed of this decision in May 2021, in October 2021 Katie Bielec was commissioned as the Independent Chair and Report Author with the aim of completing the review by April 2022. Panel meetings were held in October 2021, January, March, May and December 2022.
5. Paragraph 46 of the Statutory Guidance sets a target timescale of 6 months to complete the review, but this may need to be extended in complex cases. Due to circumstances caused by a combination of the complexities of the case and impact of Covid-19 the 6-months was not met, the Panel and Dorset CSP were updated throughout the process.
6. This review was conducted alongside an IOPC investigation, the Independent Chair worked with the IOPC to share findings and recommendations to support the review.
7. In the summer of 2023, the coroner recorded Daisy was unlawfully killed.
8. Daisy was a 51-year-old, white female at the time of her death, Robert was 55 years old, white male. Although Daisy experienced some anxiety she was not diagnosed with any disability. Robert had also experienced some anxiety but was also not diagnosed with a disability. There is no evidence to suggest that any party had particular religious beliefs and there was no indication of any pregnancy or maternity issues at the time of Daisy’s death.

# **Glossary**

* CCB – Coercive Controlling Behaviour
* DASH RIC –Domestic Abuse, Stalking and Harassment Risk Indicator Checklist.
* HRDA – Daily ‘High Risk Domestic Abuse’ meetings.
* IOPC – Independent Office for Police Conduct.
* IMR – Individual Management Reports.
* MARAC – Multi Agency Risk Assessment Conference.
* MARMM – Multi Agency Risk Management Meetings.
* SDASH - Stalking DASH – Additional questions to support the DASH RIC.
* THRIVE[[2]](#footnote-2) – Nationally Police risk matrix.

# **Contributors to the review**

1. This report has been compiled from information and facts from:
* Meeting with the family
* Reports and presentations from:
* Dorset Police
* Dorset Integrated Care Board (ICB)
* Dorset Health Care (DHC)
* Department of Work and Pensions (DWP)
* Discussions from the Review Panel members and meetings
1. The review panel consisted of agencies required within the statutory guidance and a specialist domestic abuse and stalking service. The panel members were:

|  |  |  |
| --- | --- | --- |
| **Name** | **Job Title** | **Agency** |
| Katie Bielec | Independent Chair and Report Author | Bielec Consultancy Ltd |
| Kay Wilson-White | Community Safety Business Manager (Until February 2022) | Dorset Council |
| Andrew Frost | Service Manager for Community Safety | Dorset Council |
| Diane Evans | Community Safety Business Manager (From March 2022) | Dorset Council |
| Jim Beashel | Detective Chief Inspector | Dorset Police |
| Julie Howe | Detective Chief Inspector | Dorset Police |
| Stewart Balmer | Force Reviewing Officer | Dorset Police |
| Kirsten Bland | Adult Safeguarding Lead | Dorset ICB |
| Alison Feher | Safeguarding Lead | Dorset Health Care |
| Andrea Breen | Head of Specialist Services, Adult Social Care | Dorset Council |
| Toni Sheppard | Acting Head of PDU | Probation |
| Tonia Redvers | Quality and Operations Director | The You Trust (Domestic Abuse Provider) |
| Bharati Dwarampudi | Advanced Customer Support Senior Leader | DWP |

# **Chair and Author**

1. Katie was a Metropolitan police officer, is an accredited Independent Domestic Violence Advocate (IDVA), IDVA Manager, Independent Sexual Violence Advocate (ISVA) Manager and managed domestic abuse services across the southwest for 11 years. Katie is also an associate trainer for SafeLives, Rockpool, Surviving Economic Abuse and Hampton Trust and is an accredited trainer delivering CCB, DASH and Stalking. She has completed the Home Office Domestic Homicide Review Training and is an accredited Chair with AAFDA[[3]](#footnote-3) and SILP[[4]](#footnote-4). She is a member with AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse.
2. She is a guest lecturer at Bournemouth University, has supported councils with Needs and Mapping Assessments as part of the Domestic Abuse Act 2021, has developed a Domestic Abuse Partnership Board and reviewed and commissioned domestic abuse services.
3. Katie has no personal or professional involvement with Daisy or Robert or the family. Katie managed the Dorse domestic abuse services for the You Trust during the period of the review, however, neither Daisy, Robert or any family member were involved with the service. The You Trust were panel members for their specialism regarding domestic abuse and stalking.

# **Family Background and Genogram**

1. Daisy had 5 children; her 2 eldest children were from a relationship whilst living in London. She moved to Dorset after this relationship broke down where she met her ex-husband who she had been in a relationship with for 18 years and they had 3 children together. Their marriage ended amicably in 2011.

# **Genogram**

# **Key: // = Divorced / = Separated**

 **Perpetrator - Robert** **Daisy’s new partner**

**Ex-Husband Daisy Ex-Husband**

 **Adult Child Adult Child Adult Child Adult Child Adult Child**

# **Relationship background (provided by the family)**

1. Robert lived next door to Daisy when her marriage ended, he asked Daisy out for a drink in 2013 and the relationship began. Once in a relationship he told the family he had always wanted to be with Daisy.
2. The family have reflected on Daisy’s relationship with Robert, at the time they did not have any concerns regarding domestic abuse or coercive controlling behaviour, although they remember “there were arguments over silly things”.
3. They recall Robert not understanding Daisy putting the children first and this would regularly cause arguments between the couple. At the time the family believed it was due to him not having children of his own rather than him being controlling. Additionally, Robert would tell Daisy and her children she had no consideration for him, his wants or his needs. Daisy told her children he’d argued with her saying she should be doing what he wanted to do and she would not consider him and his feelings.
4. The family feel money was used against Daisy, he always paid for holidays, the house was in his name, he paid the mortgage along with all the bills and would not agree for Daisy to be included in these. He would regularly threaten to kick Daisy out if they had an argument or if there was a disagreement.
5. The family believe Daisy’s housing was one reason, she was reluctant to leave. When the relationship had ended previously and then resumed, they believe Daisy had returned out of convenience having nowhere else to go. When Daisy left the final time, she told her family she was worried about how she was going to afford somewhere on her own.
6. In 2020 Robert suspected Daisy of having an affair and this resulted in Daisy leaving for a period of time. Daisy returned after 2 months and Robert was given access to all of Daisy’s passwords. It is unknown if Daisy was coerced into this or if it was as a result of fear.
7. Daisy had a male friend/colleague who would give her lifts to work as she was unable to drive, Robert was jealous of this friendship. On one occasion she left her phone at home whilst at work, Robert read a message from this friend/colleague offering Daisy a lift home from work, Robert then drove to her work and watched Daisy get her lift home.
8. Robert told Daisy’s family his previous partner had cheated on him which led to him having trust issues meaning he found it hard to trust anyone.
9. There were 2 occasions the family believe triggered Daisy ending the relationship:
* Firstly, an elderly neighbour passed away during February 2021, and after her passing Daisy became close to the neighbour’s son and daughters (they had known each other for several years, and the son had previously shown an interest in Daisy, but she had declined as she was in a relationship). Daisy confided with her children that she had met someone new and had noticed how different this person was compared to Robert and she was no longer happy in in her relationship with Robert.
* Secondly, in mid-February 2021 after an argument, over Daisy’s child using Robert’s food.
1. Daisy and Robert separated 2 or 3 times before the murder, this would be when arguments became too much and she needed time away from him. As a result, he would instigate the break ups by telling her to leave the house. He would then pursue Daisy with numerous messages, calls, flowers, telling her he loved her and wanted her back. He would take her out for dinner, they would spend time with each other and then get back together. Due to this, the family were not surprised by his behaviour on what was to be the final time, as he had used them before. However, the difference on this occasion was that Daisy did not respond or want to speak with him which he appeared to not be able to manage.
2. After the relationship ended at the end of February 2021, Daisy told her 2 of her children that Robert was controlling but did not explain further. The family informed the chair they had never seen any evidence or have any indication of physical violence.
3. A friend and work colleague of Daisy told police after the murder that Daisy had told her Robert was controlling towards her, there was never any violence but he could be vile and nasty to her. (It is unclear when these disclosures occurred).
4. After the relationship ended Daisy moved in with 1 of her children and grandchild, whilst one of her children continued to be a tenant at Robert's property.
5. The family believe Robert was not coping after the relationship ended. He had made them aware he was experiencing anxiety, depression, had taken time off work and this worsened once he found out about Daisy’s new relationship.
6. Although she had called the Police with concerns of him harassing her, the family do not believe Daisy recognised she was experiencing domestic abuse.

# **Chronology**

1. Prior to this relationship, Robert came to police attention for 4 x domestic related incidents with previous partners:
* In 2007 Robert’s previous partner called Police stating he had turned up at her address and was banging on the door. Due to the age of the report, there is no information regarding the outcome.
* Robert came to the attention on 3 further occasions in 2011, 2012 and 2013. These were domestic related however Robert contacted the Police presenting as a victim rather than a perpetrator (no other information was available).
1. Daisy had 12 contacts with Dorset Health Care between April 2015 to December 2018 and Robert had 3 contacts. There were no disclosures, enquiries, questions or concerns regarding domestic abuse raised by Daisy, Robert or practitioners.
2. Police had 2 contacts with Daisy and Robert during this reporting period due to concerns for the welfare of one of Daisy’s children who was in an abusive relationship.
3. Robert presented to Weymouth Urgent Care in October 2016 with an injury (not domestic abuse related). He also presented at Weymouth Minor Injury Unit in July 2017 alleging he had been assaulted by an ex-partner of one of Daisy’s children.
4. In December 2018 Daisy spoke to her GP regarding adjustment to stress describing having a difficult year with one of her children (who had left an abusive relationship) and another child (who was struggling with mental health and suicidal thoughts). She agreed to the offer of counselling.
5. In January 2019, Daisy again met with her GP regarding depression and struggling with stress. Robert also attended his GP due to stress exacerbated by the situation with one of Daisy’s children. At no stage was domestic abuse disclosed by either person.
6. In March 2019 Daisy contacted Steps to Wellbeing Service to advise she no longer required support from the service and was subsequently discharged. Advice was provided on how to re-refer to the service and her GP was informed.
7. From the period January 2019 through to end March 2021, Robert’s employers did not witness any change in his behaviour, reported his performance at work was good with no concerns.
8. In April 2019 Robert agreed to undertake Cognitive Behavioural Therapy (CBT) due to anxiety and stress attributed to the actions of one of Daisy’s children. Robert disclosed at these sessions he had feelings of anger towards them whom he alleged had been financially abusive to Daisy causing the family financial difficulties.
9. Robert completed 6 Steps to Wellbeing sessions between May and August 2019. He appeared to discern little benefit from these sessions. At his six-week review in September 2019 it was agreed he would progress to Step 3 Counselling.
10. Robert was asked about his relationship with Daisy during his counselling session in December 2019 where he ‘*became tearful and expressed feeling that he isn't able to do what a partner 'should' to support/protect his partner. He feels powerless and helpless and worries about the situation affecting their relationship as Daisy has been lying (he believes) about not giving more money to her one of her children. Robert was able to see why she might feel she has to do this. He started to think of different ways he could manage this. Talked about accepting things that he would rather have not happened. Changing what we can and accepting what we can't. Robert unsure how counselling could help him any further as he can't change the things outside his control’*. The counsellor was proactive in supporting Robert to think about his feelings differently and introduced how his thoughts may not be as he perceived them.
11. Robert engaged in two further counselling sessions before concluding that he no longer required a service, feeling that he had largely achieved his treatment goals.
12. Daisy ended her relationship with Robert at the end of February 2021.
13. A couple of days after the relationship ended Robert searched the internet regarding illegal possession of prescription drugs. He called the police and Daisy’s work stating she had left a large quantity of prescription medicine, and he didn’t want to get into trouble, he was provided appropriate advice, and no further action was taken. He then contacted Daisy’s employer regarding allegations that Daisy had a large quantity of tablets at home, he was advised how to dispose of these. They describe no concerns regarding Daisy, she was a quiet, caused no problems, was always on work on time with very little sickness.
14. Robert’s internet searches started to included locksmiths, tracking devices and how to track someone’s phone. He continued to contact Daisy’s friends and family and by the middle of March he started to search pornography and purchasing spy cameras and requested to extend his pre-booked leave from 1 week to 2.
15. At the end of March 2021 Robert was told that Daisy was in a new relationship. After receiving this information, the tone of the messages went from desperation to anger. The last communication between Daisy and Robert was at 19:30 hours, Daisy replied to a message; *“It’s not a secret. We just kept quiet to spare people’s feelings”*. Daisy blocked Robert, however, he continued to contact her family, friends and his friends/colleagues.
16. In the early hours after this message Robert searched the internet for buying chefs knives and suicide. He was engaged in a conversation with 2 friends, although the context of the conversation is unknown it led to one message stating ‘*I bet you feel like killing them both*’. At the end of the short conversation the friend signed off with *‘I will see you next week*’, Robert responded ‘*Unless I get done for murder first’*.
17. That same day Robert contacted his manager in a distressed state and disclosed his relationship had broken down. He informed them he was in touch with the Samaritans, his manager signposted him to different counselling services available through his employment.
18. Daisy called Dorset Police at 13:12 hours telling them she and Robert had separated 6 weeks earlier. He was now messaging her family, friends, her workplace and the police to get her into trouble. She told them she wanted Robert to leave her alone, confirmed she had told him not to contact her and had blocked him but he was still trying to make contact.
19. Daisy confirmed she had not been threatened by Robert but never asked if she was frightened or concerned for her safety. Throughout the call Daisy did not present as frightened being calm throughout. At times she laughed nervously when she spoke about his behaviour.
20. Daisy disclosed he knew where she lived and, although unaware if he was following her at the time, he had done so in the past. She also shared she had received 3 calls and 4 texts in 1 day along with 2 bunches of flowers over the weekend with a card saying *‘No Strings’.* She was asked for her availability over the next 3 days and accepted the offer of support.
21. The THRIVE process was followed and the call was categorised as a ‘Level 2 – Priority’ which under ‘Force Attendance Criteria’ should be attended within 60 minutes. The incident was recorded as ‘Stalking’ indicating that the call taker had identified some risks but the “banner” (the one-line entry that appears on the open summary incident which is available to those responsible for allocating and dealing with the incident) was recorded as “Harassment”. A Detective Sergeant would have assessed the intelligence associated with the message to determine if this case needed to be escalated. The entry read “*Medium Risk DA Harassment following separation of the relationship including contact to other family members. No threats made*”. The matter was not escalated and it is unclear how a robust medium risk assessment had been determined with no DASH RIC completed.
22. The incident was transferred to the ‘queues’ for allocation of an available officer and as we now know, between the point of Daisy’s call and the point of the murder; 23 hours later, the police did not see or contact Daisy.
23. Later that day Robert purchased a knife from a local store which he used to murder Daisy. He then messaged a friend (who was a work colleague) telling them he planned to visit Daisy on the day of the murder. His friend told him *“Try not to lose it”* he responded *“I don’t care what happens I just need it to hurt less. Right now, murder might be a good option.”*
24. At 01:33 hours on the day of Daisys murder Robert wrote a suicide style letter to his brother, he also sent Daisy a series of unanswered messages pleading with her to speak to him throughout the night.
25. At 11:59 hours Robert drove to the flat where Daisy was staying, whilst the family were out, Robert let himself in (it is unclear how). Daisy was on the phone to her partner; she told him Robert had come into the flat and ended the call.
26. Robert proceeded to murder Daisy and leaving the flat at 13:20 hours. Daisy was discovered by her family and died at the scene. Later that day Robert was found by police at his property where he had taken his own life.

# **Learning, Analysis and Recommendations**

1. **Learning Point 1**

**Whilst there is no evidence of physical abuse from Robert prior to Daisy’s murder, information provided by the family suggests there may have been coercive and controlling behaviour, jealousy, a probable sense of entitlement, possible use of financial control, manipulation in the attempt to resume the relationship, and harassment/stalking by Robert. At the time none of these behaviours were recognised as abusive by Daisy or those closest to her, which highlights that not all abuse is easily identifiable or considered abusive in the moment.**

1. Daisy’s family acknowledge they had felt uncomfortable with some of Robert’s behaviours but had not identified his behaviour as threatening to Daisy safety. Behaviours Robert displayed may be excused as relationship difficulties that can be ignored or ‘brushed to one side’ which makes it difficult to identify if the relationship is abusive. This is in no way to proportion blame on anyone, instead it highlights the need to be able to raise awareness in being able to identify behaviours, patterns, risks factors and how to support those who are subjected to this form of intimate terrorism.
2. Domestic abuse is being highlighted more within the public arena in areas such as TV dramas, advertising, social media and political discussion with training and contact details available to increase awareness with professionals. However, upon speaking with Daisy’s family there still appears to be limited understanding of coercive control, the behaviours associated with this type of abuse and how to identify them. There is also the issue of our societal norms around domestic abuse and how behaviours are minimised or justified. Awareness campaigns can be enhanced by having the survivor voice and being co-produced to support the narrative and how to reach those in need.
3. To raise awareness within communities in Dorset, The Dragonfly Project was created in 2018 providing Domestic Abuse workshops to anyone who wishes to attend. The vision is to bridge the gap for those in need and those who can provide support. This has been successful in its delivery and is now across 4 different counties in the country and continues to be delivered in Dorset. To support the development of this project it may benefit how outcomes can be captured with regards to the impact for victims and if communities are identifying abuse.
4. Raising awareness has been identified in The Tackling Domestic Abuse Plan 2022[[5]](#footnote-5) ‘Problem Four’, therefore, how services communicate with the public is vital in providing victims and survivors with opportunities to seek support.
5. Since Daisy’s death Dorset Council has created a Domestic Abuse Pathway on their website for victims and professionals to be able to seek support and advice and awareness raising as part of the Domestic Abuse Partnership Board Agenda.
6. **Recommendations – 1/2/3**

**Dorset's Domestic Abuse Strategy provides the foundation for and are to develop how they will:**

1. **Review the effectiveness of awareness campaigns and training, in terms of: impact, partnership working, engagement with the community and involvement of the community in design and delivery.**
2. **Identify the mechanisms for the inclusion of the voice of survivors in the development and delivery of Dorset's domestic abuse work.**
3. **Review awareness raising information and materials relating to stalking and associated risks, considering accessibility of language to the public, and revise accordingly.**
4. **Learning Point 2**

**Both had spoken to their GP and Steps to Wellbeing regarding the stress at home with Daisy’s child, this may have been an opportunity for the GP and practitioner to discuss intrafamilial abuse.**

**Developing greater awareness and confidence in dealing with the variety of situations that can arise with domestic abuse such as interfamilial abuse, including recognising subtle signs and disclosures from men, would support this.**

1. Although there is no reference of domestic abuse there is no evidence of any exploration with regards to interfamilial abuse, which Robert had made some suggestion to. This may have been due to it not being the presenting issue and his mental health was the primary focus. It is important that causal factors are further explored within assessments or planned sessions with clients to enable appropriate risk assessing, advice and support.
2. Dorset Health Care are working with the current commissioned domestic abuse provider to run several Domestic Abuse Train the Trainer events at the end of 2022. The aim being to upskill and support those within health to be able to recognise domestic abuse and to appropriately assess and respond.
3. **Recommendation 4**

**To support staff when identifying victims and possible abusers (whether in an intimate relationship or personally connected), Dorset Health Care (DHC) are to ensure a whole family approach is adopted within their domestic abuse training.**

1. **Learning Point 3**

**Daisy’s call to police indicates evidence of controlling and stalking behaviour by Robert. Robert's behaviour was concerning Daisy, who felt the need to report this to Police.**

**It is important those who receive a disclosure understand the dynamics and risk factors and clusters associated with coercive control behaviours and stalking.**

1. In isolation Robert’s behaviours may be considered minimal and non-threatening but when pieced together it creates a picture and pattern of behaviour which had an impact on Daisy.
2. Each time the relationship ended Daisy’s risk escalated. Robert used different behaviours to manipulate Daisy in resuming the relationship and on this occasion, Daisy made the decision the relationship was finally over. She changed her behaviour to manage the situation. This finality of the relationship appears to have increased Robert’s desperation, anger and attempts to make contact. Due to his previous pattern of behaviours not having the same affect, he began to use different ways to contact her and try to regain control. Daisy’s risk escalated when Robert realised these were not achieving the desired outcome.
3. The risk to Daisy increased further when Robert discovered Daisy had started a new relationship. His behaviour shifted from pleading and wanting Daisy back, to anger and rejection. He appears to be humiliated, the language used dehumanises Daisy, with him perpetuating blame on her and how he is feeling and his behaviour.
4. With these different risk factors, there is value in offering domestic abuse and safety planning training not only to frontline statutory services but anyone who may receive a disclosure or witness concerns regarding domestic abuse especially within a work setting.
5. Practitioners would benefit from having the skills and ability to explore domestic abuse and stalking, understand it’s complexities, work in a trauma informed way and know the process and pathways if there is a disclosure. To be able to support staff with routine questions within assessments and using ‘language’ which will be understood by all would enable practitioners to start open conversations and build confidence with any disclosures.
6. A greater understanding of the shift in thinking and abusive behaviours may also improve victims, families, known acquaintances, friends and other bystanders to improve confidence in seeking help and reduce concerns that they are overreacting to minor incidents.
7. **Recommendation 5**

**Domestic Abuse Partnership Board to recognize the pressure on workers to attend training and support organizations in training and learning opportunities.**

**The Domestic Abuse Commissioners Office to review the Risk Assessments currently available to ensure they are up to date with the use of technology.**

1. **Learning Point 4**

**When Daisy accepted the offer of support this would have been an opportunity for the call handler to provide details of local domestic abuse and stalking services rather than waiting for officers to make contact with her. This is especially important when there is the likelihood of a delayed response by officers.**

1. There is an acknowledgment that local commissioned services are not 24/7 services and are unable to respond immediately with regards to assessment and intervention. There would need to be a realistic expectation not only from services but also victims of the support available to them. Even though it may have been supportive to have provided Daisy with local and national numbers, due to the small amount of time from Daisy calling the police to her being murdered, advice may have been provided however a 1:1 assessment would have been booked for several days later.
2. If local services details be provided to calls that are domestic abuse related, the capacity of the services would need to be considered and how they would be able to manage the possible increase. Although this impact needs to be taken into consideration, victims must come first, therefore when they ask for help this needs to be offered as soon as possible.
3. This brings into question the commissioning of services, the additional cost on how they would be able to manage higher volume of calls and what response would be expected or be reasonably offered to any victim out of core working hours.
4. **Recommendation 6**

**To approach the Regional Office of the Domestic Abuse Commissioner to understand the impact of the changing demands on providers, and sufficiency of funding to respond.**

1. **Learning Point 5**

**No DASH was completed when Daisy called the Police, completing a DASH may have provided Daisy and the call handler an opportunity to be able to identify the abusive behaviours, the level of risk Robert posed and possible support available to her.**

**Where there is a disclosure of domestic abuse professionals (including call handlers and senior officers) it is essential they utilise the DASH questions, to support their agencies assessment.**

1. Call handlers are trained to deal with all types of calls from the public, hearing many concerns and different crimes. At the time of Daisy’s contact with them, call handlers did not complete the DASH RIC with any victim of domestic abuse. If it had been completed, they may have been able to evaluate the risk, provide immediate support over the phone and ensure it supported the future decisions of the response to Daisy.
2. Daisy had never called the police before and her family believe she called them due to being concerned as it was out of character for her. Although contacting the police can be scary, the call handler treated Daisy with respect showing empathy and understanding. It has highlighted an opportunity for system development to be able to recognise the significance of someone calling for the first time and support any risk assessment and conversation.
3. The language used on the Police information bar where stalking and harassment was noted (the information visible immediately when opened) has been highlighted as needing to reflect the most significant threat, in this case it was stalking. Daisy’s murder and her interaction with the Police will be highlighted as a “Lessons Learnt” case and used for wider training and awareness.
4. Dorset Police have recently trained frontline officers, call handlers and supervisors with DA Matters training and have designated DA Champions. This was introduced in the summer/autumn 2021 with the aim of additional awareness and the support will improve in the response to victims. It is also an action within the National Tackling Domestic Abuse Plan 2022 and Dorset Police Force Improvement Plan.
5. The Force has recognised the way calls were graded and allocated needed to be reviewed. As a result, the Call Handling Grading and Deployment Operational Procedure has been re-written to try and identify those messages that present the greatest risk and require a prompter attendance. Call takers will continue to use the THRIVE risk assessment principles, but this will be complimented by bespoke risk assessment questionnaires particularly for Domestic Abuse, Stalking and Harassment based offences (this is not the DASH or SDASH).
6. Dorset Police have adopted and implemented the college of policing guidance to responders and call takers for stalking and harassment offences. All staff within the control room have received training and are using the College of Policing question set to determine risk.
7. As part of initial learning Dorset Police will be using this within their Lessons Learnt Bulletin. This will highlight the dangers of responders being given a false sense of calmness when in fact a first-time caller as in Daisy’s case needs to be given the risk factor it deserves for no other reason than she (Daisy) had finally reached out for help.
8. **Recommendation 7**

## **Dorset Police to offer reviewing officers the Homicide Timeline[[6]](#footnote-6) and Stalker Risk Profile[[7]](#footnote-7) training to help inform decisions.**

## **Learning Point 6**

**Although Daisy’s call had been identified as a priority with an expected 60-minute response It appears the call-handler felt this may not happen, hence asked for 3 days’ worth of availability.**

**If there is a delay in police taking action victims should be kept informed and supported with how to keep safe until they can respond. This would recognise that victims can be feeling vulnerable and wanting the abuse to stop, and a delay in making this happen can heighten anxiety**.

1. There was an opportunity between 08:00 hours and 12:00 hours on the day of Daisys murder for Police to have contacted Daisy, evaluate the risk, discuss any further concerns, and explain the delay. Where delays are expected it would be supportive for victims to be kept up to date however, due to the sheer volume of calls into the Police this would not be achievable with the resources available currently.
2. As part of the review, Force Incident Managers were spoken to (they monitor open incidents and ensure attendance is speeded up if there are concerns). With the information contained within the log they were not surprised that the message had not been dealt with in the timeframe specified. The lack of supervisory intervention or an escalation of the risk to supervisors by the radio operators within the control room is currently being reviewed.
3. Dorset Police identified the attendance criteria was not serving the purpose for which it was intended (this was the legacy of an old control and command system that has now been superseded). The Force has recognised from experience at a local and national level that there is a need for a more effective risk assessment process and increased attention to calls where there is concern of domestic abuse incidents and grade appropriately.

**8.6.3 Recommendation 8**

**There was no recommendation from this learning point as action had already been taken as a result of this case.**

1. **Learning Point 7**

**The comments made within the conversation between Robert and his friends (who were also work colleagues) may have been felt as throw away comments with the appearance of someone who was upset their relationship was over. There is no evidence that these friends had any indication that Robert was realistically planning the murder of Daisy and then taking his own life. However, when friends have these types of conversations, if the behaviour or language raises concerns, how do they respond/challenge, where do they go to seek advice and support?**

**It would be reassuring if friends who are also work colleagues have a safe and supportive pathway when seeking advice within their place of work.**

**It is the responsibility of the organisation to have domestic abuse policies and procedures in place to support employees and processes should staff be concerned for a colleague not only as a victim but also where they suspect they are being abusive.**

1. The panel acknowledge the significant impact this incident may have had on Daisy and Robert’s colleagues especially for those who received calls and messages, they wish to praise the positive response from both workplaces with their support to both Daisy and Robert.
2. Robert was on leave at the time of his distressed call, his manager established that Robert was receiving immediate support. He gave no indication that he would not return to work on the Monday following his leave, of his intent to murder or take his own life. His manager had intended to revisit the discussion with him around a stress assessment and Occupational Health referral upon his return. Due to the manager taking the call on his day off, his response went above and beyond what would be expected. Additionally, he was able to offer a variety of options for Robert to consider.
3. There is a Domestic Abuse Policy in the organisation where Robert worked, however as there were no obvious indicators of domestic abuse it was not utilised. This is at no fault of the manager or Roberts colleagues, instead it highlights the need for awareness of the workplace Domestic Abuse Policy and how to access it.
4. Roberts employer’s policy team have reviewed their Domestic Abuse guidance / processes and submitted proposals to strengthen them specifically around the reporting of alleged abusive behaviour. Following consultation this was implemented from 29/12/2022.
5. The Domestic Abuse Policy and procedures need to enable staff to identify signs of abuse and how to manage a disclosure or concern. An acknowledgement of friendships outside of work and reassurance that work remains a safe space may enable staff to raise concerns whether from ‘inside’ or ‘outside’ of the workplace. Employees will require reassurance and full support of their employer with no repercussions to them within their place of work. This would need to be embedded in practice, with policies interlinking with each other (such as Supervision, Annual leave/time off work, Health & Wellbeing and Code of Conduct).
6. **Recommendation 9**

**Domestic Abuse Partnership Board to support, encourage and raise awareness of domestic abuse workplace policies.**

# **Conclusion**

1. Daisy was murdered by Robert. The evidence supports the view that Robert appears to have been a controlling and jealous individual. He had previously demonstrated stalking behaviours within the relationship, his loss of control over the relationship and his knowledge of her dating someone appears to have resulted in his finality, homicidal and suicidal actions.
2. There had been some involvement with mental health services and the GP with both Daisy and Robert, however neither person disclosed domestic abuse. There had been no police involvement or contact with Daisy until the day before her murder. Agencies had no information to indicate Robert as a potential perpetrator of domestic abuse and neither the family or agencies could have predicted he would have murdered Daisy and taken his own life.
3. There was an opportunity the police could have explored with Daisy her relationship and the harassment, identifying risks, and supporting her in safety planning and interventions. However, in light that Daisy did not demonstrate she was fearful of Robert, he had made no threat to kill/harm her or to take his own life it is difficult to determine whether the murder could have been prevented.
4. Whilst Robert appears to have demonstrated controlling, coercive and obsessive behaviours towards Daisy in and out of the relationship, this was not identified by Daisy and those around her as well as Roberts friends and family. It is therefore imperative raise awareness campaigns continue and evolve with new and emerging trends and behaviours.
5. This review has highlighted that we all have a role to play when interrupting abusers’ behaviour and supporting those subjected to abuse. This also includes survivors as well as the community, employers, support services and statutory organisations.
6. The country was experiencing a third National Lockdown, however there was no evidence this impacted either Daisy, Robert or the responses provided by agencies.

**A Poem chosen by the family and written by Donna Ashworth**

*If you think grief has a time limit,*

*You have likely never lost,*

*A piece of your heart.*

*Everything looks different and will never look the same again.*

*And that never lessens, we only become accustomed,*

*to handling it, to hiding it.*

*If you think grief has a time limit,*

*You have likely never lost a piece of your heart,*

*and for that, you should be truly grateful.*

*If you think that the days, months, and years will somehow,*

*erase the extent of the loss,*

*then you have never been unlucky enough to lose a love.*

*You are blessed, my friend.*

*For life without that piece of you, is a new life indeed.*

*It is a new world when the person you miss is no longer here.*

*Every day is a mountain to climb, battling the waves of emotion,*

*when a song plays, a smell reminds, or a memory rears.*

*You may think time is healing the hurt, then you enter a new phase,*

*of your life; a relationship, a child, a grandchild, a new opportunity*

*and you realise that you cannot share it with your missing part.*

*The waves bear down fresh as they were on the very first day.*

*Let the grieving grieve for as long as they must*

*and if you want to help,*

*love them more.*

*Love is the only way.*

**APPENDIX 1 -** **TERMS OF REFERENCE FOR REVIEW PANEL**

**Purpose of the review:**

* Establish the facts that led to Daisy’s death and whether there are any lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the family.
* Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
* Apply these lessons to service responses including challenging systemic issues and making changes to policies and procedures as appropriate.
* Improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

**Scope of the review**

The review will:

* Consider the period from 1 January 2019 to Daisy’s death subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
* Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.
* Seek the involvement of the family, employers, neighbours, and friends to provide a robust analysis of the events.
* Take account of the coroners’ inquest in terms of timing and contact with the family.
* Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a potential feature.
* Aim to produce the report within six months after the IMRs are requested, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.
* Were there any disclosure under ‘Right to know’ or ‘Right to ask’.

In addition, the following areas will be addressed in the IMR and the Overview Report:

* Were those in contact with Daisy able to identify and address any controlling and coercive behaviour as a form of domestic abuse?
* Were practitioners and the public aware of the increased risks faced by the victim post separation?
* Could more be done to raise awareness of services available to victims of domestic abuse?
* Was there recognition of the complexities within the whole family (Think Family) when working with the individuals within the family?
* Were there any barriers experienced by the victims or family, friends, and colleagues in reporting the abuse?
* Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced that were missed?
* Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
* Consider any equality and diversity issues that appear pertinent.
* Was there any impact of the Covid pandemic on those affected by or working with the family? Or could state ‘Did the restrictions placed on organisations and society as a whole due the Covid pandemic have an impact on this case?’
1. <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews> [↑](#footnote-ref-1)
2. Threat (who or what is the threat to?), Harm (what is the likely level of harm), Risk (what is the risk of the threat occurring), Investigative (what are the investigative needs and requirements), Vulnerability (of the person associated with the incident), Engagement (what is required). [↑](#footnote-ref-2)
3. https://aafda.org.uk/ [↑](#footnote-ref-3)
4. https://www.reviewconsulting.co.uk/about-us/ [↑](#footnote-ref-4)
5. <https://www.gov.uk/government/publications/tackling-domestic-abuse-plan> [↑](#footnote-ref-5)
6. <https://www.glos.ac.uk/content/the-homicide-timeline/> [↑](#footnote-ref-6)
7. <https://www.stalkingriskprofile.com/> [↑](#footnote-ref-7)