Dorset Community Safety Partnership

Domestic Homicide Review

Daisy died April 2021

Chair and Author

Katie Bielec

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**Foreword – Daisy’s children**

*We all knew her, we all love her, she influenced all 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 met. 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 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 and 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 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 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 would be surprised how far this belief can go.*

*She was also blessed with four grandchildren who 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 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 is 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 everything 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 is 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.”*

# **1 Introduction**

1. Dorset Community Safety Partnership, the independent chair and panel members want to offer their deepest sympathy and condolences to Daisy’s family and friends. The chair would also like to thank all those who contributed to the review, for their honesty, time, reflection, and support.
2. This Domestic Homicide Review (DHR) is a statutory requirement which will examine agency responses and support given to Daisy (not her real name) and that of Robert (not his real name), a resident in Dorset prior to her murder and his death in April 2021.
3. Daisy was murdered by her ex-partner Robert, who then took his own life. Daisy had 5 children and 4 grandchildren and was living with one of her children and grandchildren at the time of her death.
4. Due to Daisy and Robert having been in a relationship prior to her murder and Robert’s death, Dorset Community Safety Partnership (CSP) identified the case met the criteria for a DHR.
5. The review will consider agency contact and/or involvement with Daisy and Robert between 01/01/2019 and Daisy’s death. Agencies were asked to consider any events outside of these dates for this review should there be any relevance.

# **2 Glossary**

1. DASH RIC**[[1]](#footnote-1)** – The nationally accredited SafeLives Domestic Abuse, Stalking and Harassment (DASH) Risk Indicator Checklist is a tool designed to provide a consistent way for practitioners who work with adult victims of domestic abuse to help identify those who are at high risk of harm and manage their risk.
2. SDASH - The SDASH (Stalking DASH) is designed to support professionals identify stalking behaviour and professional judgement when considering risk, support, and intervention.
3. HRDA – High Risk Domestic Abuse daily meeting with partner agencies to discuss risks and create an action plan to safety plan for the victim, children, and intervention for the perpetrator.
4. MARAC – Multi Agency Risk Assessment conference, a monthly meeting to discuss high risk domestic abuse cases with the aim to increase safety, reduce risk and interrupt the abusive behaviour of the perpetrator.
5. IDVA – Independent Domestic Violence Advocate, support for high-risk victims of domestic abuse.
6. ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.
7. AAFDA – Advocacy After Fatal Domestic Abuse, Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support
8. THRIVE – a nationally implemented risk matrix used to assess risk and determine response. 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).
9. IAPTUS – Dorset Health Care (DHC) electronic patient recording system for psychology services.
10. RiO – DHC electronic patient recording system for community and inpatient mental health services.
11. SystmOne – DHC electronic patient recording system for community physical health services.
12. MARMM – Multi Agency Risk Management Meetings, a multi-agency meeting to discuss support and create an action plan.
13. CCB – Coercive Controlling Behaviour

# **3 Timescales**

1. Shortly after Daisy’s death Dorset CSP received a Domestic Homicide Review Referral regarding the murder of Daisy from Dorset Police. The decision to carry out the review was made that month, and the Home Office was informed in May 2021. The Independent Chair and Report Author was commissioned in October 2021 with the aim of completing the review by April 2022. Panel meetings were held in October 2021, January, March, and May 2022.
2. The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016, paragraph 46 states that the target timescale for completion of the review of six months 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 this has now surpassed the 6 months, with the approval of the Panel and Dorset CSP.

# **4 Confidentiality**

1. In line with Home Office Statutory Multi-Agency Guidance paragraph 75, to protect the identity of the victim, perpetrator, relevant family members, staff, and others to comply with the Data Protection Act 1998 pseudonyms have been used which were chosen by Daisy’s family.
2. The sharing of information between agencies in relation to this review was underpinned by the Partnership Personal Information Sharing Agreement (PISA) which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004 to establish and coordinate a DHR.
3. Panel meetings were all confidential and any sharing of information to third parties was carried out with the agreement of the responsible agency’s representative, the panel and chair.
4. The findings are restricted to authors of the reports, their managers and panel members. Once agreed by the Dorset CSP, the Home Office will be informed, and it will be presented to the Home Office Quality Assurance Panel for final approval. Initial learning identified through the Review process will be acted on immediately.

# **5 Terms of Reference**

1. Purpose of the review

The purpose of the review is to:

* Establish the facts that led to Daisy’s murder 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 any 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.
1. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.
2. Scope of the review

The review will:

* Consider the period from 01/01/2019 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 Individual Management Reviews and the Overview Report:

* Were those in contact with Daisy able to identify and address if there was 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?
* ‘Did the restrictions placed on organisations and society as a whole due the Covid pandemic have an impact on this family?’

# **6 Methodology**

1. Domestic Homicide Reviews became statutory on 13/04/2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1. The principles of the review have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews – Revised Version – December 2016[[2]](#footnote-2).
2. The purpose of a DHR is to:
* Establish what lessons are to be learnt from the domestic homicide/suicide regarding the way in which local professionals and agencies work individually and together to safeguard victims.
* Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
* Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
* Contribute to a better understanding of the nature of domestic violence and abuse.
* Highlight good practice.
1. The chair met with Daisy’s family who was able to provide invaluable insight into Daisy’s background and the relationship she had with Robert.
2. The chair has heard the recording of the call made to Police by Daisy as well as being provided a transcript of the call.

1. Various pieces of research have been used within the analysis and are referenced throughout the report.

# **7 Involvement of Daisy’s family, friends, and employers**

1. The chair and the panel would like to thank Daisy’s children (all are adults) with their involvement of the review. Discussions with 2 of Daisy’s children enabled the panel to understand the relationship and the dynamics within it. Daisy’s 3 other children were all offered to speak with the chair, however they were happy to have all correspondence via their other siblings.
2. The option for the family to speak with the chair remained open throughout the review process. They were supported by a Victim Support Homicide Support Worker and were kept up to date with any new information. They were also provided details of AAFDA for any additional support. The family were offered to attend the panel meeting but unfortunately this was not possible due to work and personal reasons. However, the chair remained in contact with both the family and the advocate throughout the process.
3. The chair attempted to contact a friend and work colleague of Daisy but unfortunately was unsuccessful. However, their statements were shared by the Police which have been included within the review.
4. Daisy was employed at the time of her murder, with her employer providing information and statements to the Police as part of their investigation. In consultation with the Police, it was not felt appropriate for this review to approach her employer due to the limited information they had regarding Daisy and Robert’s relationship.

# **8 Contributors to the review**

1. Agencies were identified by Dorset Community Safety Partnership (CSP) and the Review Panel as having information regarding Daisy and Robert. They were able to provide a chronology of events and Individual Management Review (IMR) recording their contact, analysis of performance, identifying good practice and any recommendations for improvement.
2. This report has been compiled from this information and facts from:
* Meeting with the family
* Reports and presentations from:
* Dorset Police
* NHS Dorset (formally NHS Dorset Clinical Commissioning Group)
* Dorset Health Care University NHS Foundation Trust
* Department of Work and Pensions (DWP)
* Discussions from the Review Panel members and meetings
1. The panel comprised of agencies who had information regarding Daisy and Robert. Agencies were also invited to be present at the panel who held no information but due to their expertise were able to add value in the discussions and contribution to the report. All panel members were required to review each IMR, provide feedback at panel meetings and support the process. An additional contributor to the review due to their involvement with Robert was his employer.
2. The review panel consisted of:

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| **Name** | **Job Title** | **Agency** |
| Katie Bielec | Independent Chair and Overview Report Author | Bielec Consultancy Limited |
| Kay Wilson-White | Community Safety Business Manager (Until February 2022) | Dorset Community Safety Partnership |
| Andrew Frost | Service Manager for Community Safety | Dorset Community Safety Partnership |
| Diane Evans | Community Safety Business Manager (From March 2022) | Dorset Community Safety Partnership |
| 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 | NHS Dorset |
| Alison Clark | Safeguarding Lead | Dorset Health Care |
| Andrea Breen | Head of Specialist Services | Dorset Adult Social Care |
| 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 | Robert’s employer  |

# **9 Author of the Overview Report**

1. Katie Bielec was appointed the Independent Chair and author for the review. Katie was a Metropolitan police officer for 5 years working frontline and Hammersmith Borough Intelligence Unit (BIU). She is a trained IDVA, IDVA manager and ISVA manager, managing domestic abuse services across Dorset and Somerset for 11 years with the You Trust until September 2021.
2. She is an independent MARAC chair and has chaired MARMMs and Stalking Clinic in Dorset. She is an associate trainer for SafeLives, Surviving Economic Abuse and Rockpool, delivers Project CARA for The Hampton Trust and is an accredited trainer delivering Coercive Controlling Behaviour (CCB), DASH RIC and Stalking.
3. Katie has completed the Home Office Domestic Homicide Review Training and is an accredited Chair with AAFDA, is a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse.
4. She is a guest lecturer at Bournemouth University, has supported councils with Needs and Mapping Assessments as part of the Domestic Abuse Act 2021 requirements, has developed a Domestic Abuse Partnership Board, reviewed, and commissioned domestic abuse services.
5. Katie is not associated in any way to any agencies who have provided information for the review or had any personal or professional involvement with Daisy or Robert’s or the family. Katie managed the Dorset domestic abuse services for the You Trust during the review period, however, no person discussed within the report was not involved with the service.

# **10 Parallel Reviews**

1. This review was conducted alongside the IOPC which was concluded at the end of 2022.
2. The inquest was held in summer 2023, the coroner recorded Daisy’s death as an unlawful killing.

# **11 Equality and Diversity**

1. The chair and panel members considered whether the protected characteristics of:
* Age
* Disability,
* Gender reassignment,
* Marriage and Civil Partnership,
* Pregnancy and maternity,
* Race
* Religion and belief,
* Sex
* Sexual orientation,

were relevant in this review.

1. Daisy was a 51-year-old, white female at the time of her death, Robert was 55 years old, white male. The Office for National Statistics (ONS)[[3]](#footnote-3) data found that year ending March 2022 showed 1.7 million women experienced domestic abuse and female victims were more commonly killed by a partner or ex-partner (33%). Therefore, due to Daisy’s sex she was at higher risk of being a victim of domestic abuse.
2. There is no information to suggest Daisy had a disability although it is noted that she had experienced some anxiety, however, was not diagnosed as a disability. Robert had also experienced some anxiety, again this was not diagnosed as a disability.
3. There is no evidence to suggest that any party had religious beliefs and there was no indication of any pregnancy or maternity issues at the time of Daisy’s death.

# **12 Dissemination**

1. Once notification has been received from the Home Office that the reports have been agreed, they will be shared with the family who will also be supported throughout the publication of the reports.
2. They will be published on the Dorset Council website[[4]](#footnote-4) and shared with the Dorset CSP Board, review chair and panel, Dorset Police Crime Commissioner (PCC) and the Domestic Abuse Commissioner.

# **13 Homicide – The Facts**

1. Daisy ended the relationship with Robert at the end of February 2021.
2. In the early evening at the end of March 2021 Robert was informed that Daisy had started a new relationship. Evidence gathered by police indicate that after receiving this information Robert started to escalate his contact with Daisy, her friends, family, and work.
3. Between 23:37 hours – 11:39 hours (the next day day) Robert searched the internet for help for suicidal thoughts and where to purchase chef knives and pens a suicide type letter to his brother. He was also engaged in conversations with 2 friends regarding him speaking to Daisy. The same day Robert purchased a Chefmans knife from Wilkinson’s (which was used in Daisy’s murder).
4. Later that day at 13:13 hours Daisy called the police stating she was being harassed by Robert. She told them he had sent her flowers, was messaging people she knew, she had blocked him from all social media and her mobile phone and wanted him to stop.
5. Robert searched the internet at 13:50 hours on how to self-harm by hanging or bleeding to death.
6. At 15:59 hours, he told a female friend he was going to visit Daisy the following day. He also contacted one of Daisy’s children and other, people seeking recommendations for mental health support as he was “falling to bits”.
7. In the early morning after Daisy had called Police, Robert sent a series of unanswered messages to Daisy asking her to speak with him.
8. At 11:59 hours that day (CCTV shows) Robert drove to Daisy’s youngest child’s flat where Daisy was staying. After Daisy’s child and grandchild left the property for an appointment, Robert entered the flat. It is not clear how he gained access to the property as Daisy was on the phone at the time to her new partner. She told him that Robert was there and ended the call. Robert proceeded to stab Daisy to death, leaving the flat at 13:20 hours.
9. At 17:41 hours Police received a call from Ambulance Control to inform them they were responding to a female with stab injuries after Daisy had been found by her family.
10. Later that day one of Roberts tenants contacted the police due to concerns they were unable to access Robert’s house. Police later found him at his property where he had taken his own life by hanging.

# **14 Family and relationship background.**

1. Daisy had her eldest child when she was 16 years old, she lived in London with her 2 eldest children. They described this time as difficult for Daisy explaining she would not eat so they could eat. Daisy had custody of the children due to a violent incident with her then ex-partner who was also the father of her 2 older children. After this relationship ended there was little involvement by the father. Daisy left London relocating to Dorset, the children were 3 and 5 years old at the time and they lived with a friend and her children.
2. Daisy then met her second husband (not Robert) who was in the armed forces. They had 3 children together and moved around the southwest of England finally settling back in Dorset.
3. Daisy and the 3 youngest children’s father were together for 18 years and married 16 years. The children remember it as a happy relationship however they remember some arguing but stated this was kept private.
4. The family explained that Daisy and her ex-husband (not Robert) had always stated they loved one another, however they argued more than not, and they made the decision to end the relationship. They state there was no abuse within the relationship and both parents remained in close contact and supported each other up until her death.

#  **15** **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**

# **16 Background of the relationship – Information provided by Daisy’s family.**

1. Robert lived next door to Daisy and her family whilst she was married (it is not known how long they were neighbours); he had told the family he had always liked Daisy even when she was with her husband. Daisy’s family state whilst she was married her relationship with Robert had always been neighbourly.

1. In 2011 Daisy’s marriage ended.
2. In 2013 Daisy joined an internet dating site and the family believe Robert was aware of this. He then asked Daisy out and later told her children he had always known he had wanted to be with her. They claim Daisy initially made it clear to Robert she needed more time and told them “He was not the ‘best looking’ guy but treated her well”. They recall this was a trait Daisy liked in Robert, the relationship started in late 2013/2014.
3. The family have reflected on Daisy’s relationship with Robert and identified at the time they did not have any concerns regarding domestic abuse or coercive controlling behaviour, although they remember and stated, “there were arguments over silly things”. They recall the arguments were mostly over Daisy’s children and how much time she would want to spend with them. They explained it appeared he did not understand that Daisy would put the children first, at the time the children thought it was because he did not have children rather than him being controlling.
4. They recall how Robert would want to spend time alone with Daisy, they stated Robert would find it difficult when Daisy worked during the week and wanted to see the children at the weekend. She had told them that if she were tired after work and wanted to go straight to bed, he would say to her that she did not want to spend time with him, making her feel bad.
5. The family felt one of the main issues was that he would say to Daisy and her children there was no consideration for him, his wants, or his needs. They gave an example, of an argument on holiday where he wanted to swim in the sea, but Daisy did not. Daisy told her children he had argued with her saying she should be doing what he wanted to do, and she would not consider him and his feelings.
6. Her children are unaware of Daisy ever raising concerns about the arguments at the time, however after Daisy and Robert separated, she told 2 of her children that he was controlling but did not explain further. The family did not see any evidence and there was no indication of physical violence by Robert on their mother.
7. Upon reflection 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 to have Daisy included in these. They also recall that he would regularly threaten to kick their Mum out if they had an argument or there was a disagreement. Looking back now, the family are asking themselves *“Did Robert just lend us the money, so he had some form of power over Mum. Mum would not leave as the kids owed him money and she had nowhere to live.”*
8. The family believe the situation regarding the home and where Daisy could live was one reason why she was reluctant to leave. They had separated a year before her death and Daisy briefly stayed with her 2 of her children. When the relationship resumed the family were concerned Daisy was staying for convenience as she had nowhere else to go. When Daisy left before her death, she told her family she was worried about how she was going to afford somewhere herself.
9. The family reported to the Police after Daisy’s murder that Robert would sulk and could go days and weeks without talking to her. They reported an incident in 2020 where Robert suspected Daisy of having an affair and this had resulted in Daisy leaving for a period. When Daisy went back after 2 months, Robert was given access to all of Daisy’s passwords. It is unknown if Daisy was coerced into this or if it was because of fear.
10. The family recall Daisy had a male friend, a work colleague, who would give her lifts home due to Daisy not being able to drive. Two of Daisy’s children stated she had told them the relationship was never romantic, but Robert was upset with this friendship. On one occasion she left her phone at home whilst at work, her friend had messaged her offering a lift. Robert read the message and drove to her work to watch Daisy get her lift home.
11. Robert informed Daisy’s family his previous partner had cheated on him which led to him having trust issues and he found it hard to trust anyone. They do not know if this was true, but he used it as an excuse for his behaviour. It is unclear who this partner was as Robert’s brother informed police that Robert’s marriage had ended amicably.

1. There were 2 occasions which the family believe triggered Daisy to end the relationship for the final time:
* Firstly, an elderly neighbour passed away during February 2021. 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 1 of 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 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, the family remember each time the relationship ended. This would be when arguments became too much, and she needed time away from him. As a result, Robert would instigate the break ups by telling her to leave the house, but would always pursue Daisy to get her back, bombarding her with messages, calls, flowers, telling her he loved her and wanted her back. He would take her out for dinner, they would spend time together and then get back together. Due to this, they were then not surprised by his behaviour before the murder as he had used them before. The difference on this occasion was that Daisy did not respond or want to speak with him which he appeared not to be able to manage.
2. 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. Robert told Daisy’s child he wanted them out but retracted this saying it was said out of anger and that they were able to continue living at his property.
3. The family feel 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 had worsened once he found out about Daisy’s new relationship.
4. When Robert heard of Daisy’s new relationship, he rang one of Daisy’s children asking if they knew why their relationship had broken down. They stated they did not say much to him “as I wanted to keep the peace”. Throughout the call he continued to tell them that Daisy had a new man. They are aware he then called other members of Daisy’s family, work, and the Police (as detailed in the chronology).
5. The family stated they do not believe Daisy would have made the call to Police easily, she would have only called if the problem was “big”. They told the chair “We don’t know if it would have made a difference, if the police had spoken to her and then to him, would it have made a difference?”
6. When the relationship ended, she told 2 of her children that Robert was controlling (but never explained further) and she felt he would not leave her alone. Although she had called the Police with the concerns of him harassing her, the family do not believe Daisy recognised she was experiencing domestic abuse.
7. 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).
8. When the family reflect on Robert in their lives and in a relationship with Daisy, they would have described him as a nice guy, who would do anything for anyone, friendly and jokey. They recall how he would always be there for Christmas and birthdays, and he would pay for trips and meals out. They never had any indication that he would do this to their Mum but with hindsight they have identified some possible abusive behaviours.

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| **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.  |

# **17 Chronology – Information provided by organisations involved with Daisy and Robert.**

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 where domestic related however Robert contacted the Police presenting as a victim rather than a perpetrator (no other information available).
1. Between April 2015 to December 2018 there were 12 contacts with Daisy and Dorset Healthcare. Daisy reported issues with physical ailments requiring physiotherapy, or stress and anxiety due to personal issues regarding 1 of her children resulting in referrals to Steps to Wellbeing and counselling. Robert had 2 contacts with Weymouth Minor Injuries Unit with conjunctivitis and shingles. There were no disclosures, enquiries, questions, or concerns regarding domestic abuse raised by Daisy, Robert, or practitioners.
2. During the same period Police had 2 contacts with Daisy and Robert due to concerns of domestic abuse within one of Daisy’s children’s relationships.
3. Early in October 2016 Robert presented at Weymouth Urgent Care Centre with a laceration to his head reportedly resulting from a car boot falling on his him. There was no loss of consciousness, and he was bright and alert, after observations and the wound being treated, he was provided with head injury information and discharged.
4. At the beginning of July 2017 Daisy and Robert attended the home address of 1 of Daisy’s children to collect her belongings following a breakdown of a relationship, Robert was assaulted by the ex-partner as a result. Police were called, however, both Daisy and Robert did not want to make statements and the case resulted in No Further Action.
5. In mid-July 2017 Robert presented at Weymouth Minor Injury Unit alleging an ex-partner of Daisy’s children had held him in a choke hold in an earlier incident. There is no evidence within the records this was explored further by health professionals with regards to any risk or support for him or Daisy.
6. In December 2018 Daisy informed her GP she was struggling with her mood as 1 of her children was a victim of domestic abuse but was now safe. This was reiterated during an assessment completed by a Psychological Wellbeing Practitioner. Within the assessment Daisy presented with symptoms of adjustment to stress, she described a difficult year supporting her child who had left an abusive relationship and 1 of her children was struggling with their mental health and suicidal thoughts. The agreed outcome was for counselling when a place became available.
7. In January 2019 Robert sought support from the GP due to stress from the situation at home with 1 of Daisy’s children and work. He was offered a sick note which was declined. Robert was seen in early February, and he informed the GP that work had improved but 1 of Daisy’s children was still causing stress. There is no evidence the GP discussed domestic abuse or explored further happenings within the home.
8. At a depression review with her GP in January 2019 Daisy informed them her mood had slightly lifted but there continued to be ongoing stress. She was seen later in February at another review and was waiting counselling due to still struggling. Her Fluoxetine medication was slightly increased, and a 3 week follow up appointment was booked, however there are no records to indicate this follow up occurred.
9. Daisy called police in February 2019 concerned for her child’s abusive relationship.
10. A letter in March 2019 shows that Daisy contacted the Steps to Wellbeing Service to advise that she felt she no longer required support from the service, and she was subsequently discharged. Advice was provided about how to re-refer to the service should this be helpful in future and her GP was informed. This response was in accordance with the Steps to Wellbeing Procedures therefore no further contact would have been made by them.

1. Robert had an assessment carried out by a Psychological Wellbeing Practitioner in April 2019 with the agreed outcome to undertake Cognitive Behavioural Therapy (CBT), guided self-help sessions related to anxiety and stress attributed to the actions of Daisy’s child. He was invited and agreed to commence with an educational orientation session to help prepare for psychological work.
2. Robert’s IAPTUS notes indicate he had feelings of anger towards 1 of Daisy’s children whom he alleged had been the perpetrator of financial abuse to his mother and sister and had caused the family significant financial difficulties.
3. Robert completed six Steps to Wellbeing sessions between May 2019 and late August 2019. From these notes the practitioner indicated Robert appeared to discern little benefit from these sessions. When he attended a six-week review at the end of September 2019 it was agreed he would progress to Step 3 Counselling.
4. During a counselling session in December 2019 Robert was asked about his relationship with Daisy, the notes state *‘became tearful and expressed feeling that he is not 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 child. 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 cannot. Robert is unsure how counselling could help him any further as he can't change the things outside his control’.* Within this session he called Daisy a liar and blamed her for helping her child financially. 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. Robert engaged in two counselling sessions before concluding that he no longer required the service, feeling that he had largely achieved his treatment goals.

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| **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. Daisy ended the relationship with Robert at the end of February 2021.
2. Police discovered two days after Daisy ended the relationship, Robert researched on-line whether it was illegal to be in possession of prescription drugs. The following day he contacted Dorset Police to report he had found a large quantity of prescription medication at his home which belonged to his ex-partner. He implied that he did not want to get into trouble because he was a “civil servant”, and he did not think Daisy should have them. He also told police that he had informed the manager at her place of work. Robert was correctly advised to return the medication to a pharmacy and the allegation/incident was closed and no further action taken.
3. Daisy’s employer received a call from Robert regarding allegations that Daisy had a large quantity of tablets at home, he was advised how to dispose of these. They describe they had no concerns regarding Daisy as she was a quiet person, who caused no problems, was always on work on time with very little sickness.
4. Police also found Robert’s internet searches continued to fluctuate from finding a locksmith, how to change the lock and how to track someone’s phone. These searches were punctuated with messages to Daisy, family members and two personal friends (who were also work colleagues).
5. In mid-March 2021 Robert’s request to extend his pre-booked leave from 1 week to 2 was granted. Robert’s work confirmed from January 2019 to end March 2021, they were not witness to any change in Robert’s behaviour, reported his performance at work as good, with no areas of concern. He was considered as an experienced work coach who supported several colleagues consolidating their learning.
6. Robert’s internet searches started to included pornography and the purchase of spy cameras.
7. At the end of March 2021, a neighbour told Robert that Daisy was in a new relationship. The neighbour then informed the new partner of the conversation who in turn told Daisy.
8. After Robert received this information, his messages changed from wanting Daisy back to one of accusation and anger towards what she had apparently done. Robert contacted people close to him including Daisy’s family members to update them of his new information and accusing her of having “secret shags”.
9. The last dialogue between Daisy and Robert was at 19:30 hours two days prior to killing her when she replied to him *“It’s not a secret. We just kept quiet to spare people’s feelings”.*
10. After this message Daisy blocked Robert by all means, this appeared to enrage Robert and he continued to try and contact her via friends and family. Those who he contacted empathised with his situation, but no-one was aware of his intentions. Within these conversations/messages Robert mentioned he needed some mental health counselling, in response to this, Daisy’s family signposted him to Steps to Wellbeing. Daisy was aware of these calls and messages but did not respond to him.
11. At 01:33 hours the day before Daisy was killed Robert wrote a suicide style letter to his brother[[5]](#footnote-5).
12. Police investigating the murder found that at 03:00 hours Robert’s web history changed, he read about buying chefs knives which he later purchased from a local store (weapon used in the murder) and by the afternoon of that day he was researching suicide.
13. A few hours after these searches Robert was engaged in a conversation with 2 friends (via Messenger). The context of the conversation leading up to a comment made by Robert is not available, however it led to one of the friends responding with ‘*I bet you feel like killing them both’*. After a short conversation, the friend signed off by saying ‘*I will see you next week*’ to which Robert responded, ‘*Unless I get done for murder first*’.
14. Later that same day, Robert contacted his manager via telephone, it was his manager’s non-working day, but he took the call.
15. Robert was in a distressed state and disclosed that his relationship with his partner had broken down. His manager signposted Robert to PAM Assist Counselling (a service provided by his employer) and spoke about the benefits of counselling. They also highlighted services available through Live Well Dorset and Trade Union colleagues. Robert told his manager he was in touch with the Samaritans.
16. Daisy contacted Dorset Police at 13:12 hours that same day to report Robert for harassing her. Within this call she informed the call handler that she and Robert had separated 6 weeks earlier and he was now messaging all her family, friends, work as well as the police to get her into trouble. She stated he just needed to leave her alone, she confirmed she had told him not to contact her and she had now blocked him. He had made attempts to contact her on social media, which she had also blocked him on, and this appeared to have increased him contacting other people.
17. Within the conversation Daisy explained Robert had been informing people she was seeing someone whom she had had an affair with 10 years ago, Daisy confirmed she did not know the other person 10 years ago.
18. The call handler asked if Robert had threatened her which Daisy answered “*No*”, however at no point did the call handler ask if Daisy was frightened or concerned for her safety.
19. Daisy explained Robert was aware of the location, but she was unaware if he was following her stating he had followed her previously when they were together.
20. Daisy confirmed she received 3 calls and maybe 4 texts a day and he had sent flowers on 2 occasions over that weekend, with a card saying ‘*No Strings*’.

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| **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. At the end of the call the call handler asked Daisy if she would like her details to be passed to a support agency which Daisy accepted.

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| **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 contact her. This is especially important when there is the likelihood of a delayed response by officers. |

1. Following the call, the THRIVE process was followed, and Daisy was categorised as a Level 2 - Priority. THRIVE identifies the following information:

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| **THRIVE** | **Daisy’s risk** |
| Threat | Harassment from ex-partner |
| Harm | Unwanted contact from ex-partner |
| Risk | High |
| Investigation | Named person (Robert) |
| Vulnerability | DA Related |
| Engagement | Passed reference number and availability taken |

1. Level 2 - Priority under Force Attendance Criteria should be attended within 60 minutes. However, the call handler asked Daisy’s availability over the next 3 days which Daisy provided.
2. The matter was recorded as ‘Stalking’ indicating that the call handler had identified some risks and behaviours 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”.
3. The call handler forwarded the open message within the control room environment to a Detective Sergeant who would have assessed the intelligence associated with the message to determine if it were to be escalated. The entry reads “*Medium Risk DA Harassment following separation of the relationship including contact to other family members. No threats made*”. The matter was not escalated, it is unclear how a medium risk assessment had been determined with no DASH RIC completed.

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| **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. The incident was transferred to the “queues” for allocation of an available officer and as we now know that between the point of her call and the point of the murder 23 hours later, Daisy was not seen by Police.

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| **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. Robert sent a message via messenger to a friend that he was going to visit Daisy the following day. They responded “*Try not to lose it*”, to which he answered “*I don’t care what happens I just need it to hurt less. Right now murder might be a good option*.”

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| **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 with clear processes should staff be concerned for a colleague, not only as a victim, but also where they suspect they are being abusive. |

1. Robert’s call data and history shows he was awake throughout the night into the morning of Daisy’s death. He sent Daisy a series of unanswered messages pleading with her to speak to him, she did not respond as she had blocked him from any communication.
2. At 11:59 hours Robert drove to the flat where Daisy was staying. Whilst Daisy’s family were out, Robert let himself into the flat. Daisy was on the phone to her new partner; she told him Robert was there and ended the call. Robert proceeded to murder Daisy, leaving the flat at 13:20 hours.
3. At 17:41 hours the same day, police were informed by Southwest Ambulance Service that they were responding to a female with stab injuries, Daisy had been found by her family. She was pronounced dead at the scene.
4. Later that day a tenant from Robert’s property contacted the police concerned they were unable to gain access. Police found Robert at his property where he had ended his life by suicide.

# **18** **Analysis and Recommendations**

Note: Within the analysis there will be reference to the Homicide Timeline stages:

• Stage 1 – A History of control or Stalking

• Stage 2 – The commitment whirlwind

• Stage 3 – Living with control

• Stage 4 – Trigger

• Stage 5 – Escalation

• Stage 6 – A change of thinking

• Stage 7 – Planning

• Stage 8 – Homicide and/or suicide

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. The Government introduced a new domestic abuse offence in Section 76 of the Serious Crime Act 2015[[6]](#footnote-6) of Coercive and Controlling Behaviour which came into effect on 29/12/2015.
2. The offence of coercive and controlling behaviour introduced a new set of behaviours that could be classed as domestic abuse. Coercive control is defined as ongoing psychological behaviour, rather than isolated or unconnected incidents, with the purpose of removing a victim's freedom.
3. The Government definition also outlines the following:

“Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

“Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.”

1. Since Daisy’s death the Domestic Abuse Act 2021 introduced an amendment[[7]](#footnote-7) to S76 Serious Crime Act 2015, this now includes victim can be subjected to coercive controlling behaviour once the relationship has ended (this came into effect in 2023). There have been awareness campaigns to highlight these changes, and this will continue to be part of any communication in the future.
2. Coercive control can at times be ‘hidden in plain sight’ and at times excused by those around the relationship and in the context of an abusive relationship Robert displayed jealous and controlling behaviour, for example he seemed to have been unable to understand Daisy’s relationship with her family and control it. At times it appears he presented having a sense of entitlement over the relationship with an expectation of how Daisy should behave and when and if the relationship should end.
3. Robert used to excuse his jealousy and trust issues because of his ex-partner ‘*cheating on him*’. Abusers will often blame[[8]](#footnote-8) others (in this case his ex-partner) to justify their behaviour, proportioning blame on another and taking no responsibility for their actions. This appears to be the case with Robert.
4. Robert demonstrated jealous behaviours including when he accused Daisy of having an affair and her relationship with the male colleague. When the relationship resumed after one separation his jealousy seemed to continue as it is believed he was given access to all her passwords. It is unclear if this was a voluntary gesture by Daisy, however when considering his jealousy, it demonstrates continued coercion control which in turn possibly isolated Daisy from friends. However, this behaviour could be recognised as technology-facilitated abuse. Robert having full access to Daisy’s accounts enabled him to have access to her location and social media accounts which would have created a barrier for Daisy to safely communicate with family and friends without Robert being made aware, creating another layer of coercive control, stalking and jealousy increasing Daisy’s risk.
5. Jane Monkton-Smith explains this further within The Jealousy Code (Monkton Smith J. , 2021, pp. 78 - 80) *‘jealousy is often used as a ‘crime of passion’ narrative as a defence for murder’*. She describes the jealousy code as a pattern of behaviours that impacts on the victim, isolating them even further when in an abusive relationship. ‘*Excessively jealous people have their feelings of entitlement validated through these social scripts’*. She goes on to explain that ‘*Excessive or persistent jealousy reflects a behavioural pattern, a way of thinking, a constant threat. The jealousy code and the myth of the crime of passion give power to controlling people because they have become plausible explanations for what is actual control’.*
6. Daisy’s family acknowledge on occasion they felt uncomfortable with some of Robert’s behaviours and may be perceived by those without knowledge or experience of abusive relationships as non-threatening. These behaviours may be excused as relationship difficulties that can be ignored or ‘brushed to one side’ which makes it difficult to identify if you or a person you know is in an abusive relationship. 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[[9]](#footnote-9).
7. Domestic abuse is being highlighted more within the public arena such as TV dramas, advertising, social media, and political discussion with training 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.
8. 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 impact for victims and if communities are identifying abuse.
9. Raising awareness has been identified in The Tackling Domestic Abuse Plan 2022[[10]](#footnote-10) Problem Four, therefore, how services communicate with the public is vital in providing victims and survivors opportunities to seek support.
10. Since Daisy’s death Dorset have created a Domestic Abuse Pathway on their website for victims and professionals to be able to seek support and advice as well as having awareness raising as part of the Domestic Abuse Partnership Board Agenda.

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| **Recommendation**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 DA work.
3. Review awareness raising information and materials relating to stalking and associated risks, considering accessibility of language to the public, and revise accordingly.
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**18.2 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 possible intrafamilial abuse.**

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

1. In the absence of any indication of domestic abuse by Daisy either from the GP referral or the telephone assessment with Steps to Wellbeing, the decision not to pursue counselling sessions would appear to have been Daisy’s alone and the process followed was in line with Steps to Wellbeing Procedures.
2. Accordingly, there appears to have been no suggestion from Daisy, use of any ‘trigger words’ or her displaying any behaviours that she was experiencing abuse which may be why the GP was unlikely to have considered domestic abuse to be the cause of her stress.
3. It may have been of some benefit for the GP to have followed up the reasons for Daisy no longer requiring support but again this is not common practice and considering the demands on the NHS and GPs at this time due to COVID it would not have been expected.
4. The 2 contacts with Robert and the GP showed good practice in managing his low mood, with an appropriate onward referral and follow up. There were no disclosures of any issues with his relationship to any of the practitioners, and there does not appear to be anything in his history or any flags on his notes to suggest he posed any risk.
5. 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 as it was not the priority presenting issue and his mental health was the primary focus for the practitioner. It is important that causal issues are further investigated within either assessment or planned sessions with any client to enable appropriate risk assessing, advice and support.
6. 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 with the aim to be able to upskill and support those within health to be able to recognise domestic abuse and how to assess and respond most appropriately.

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| **Recommendation**1. 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.
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**18.3 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.**

**For those who receive a disclosure it will assist in their response to victims if they understand the dynamics, risk factors and clusters associated with coercive control and stalking.**

1. ‘Stage 4 – Trigger’ of the Homicide Timeline explains the trigger to a perpetrator increasing their abusive behaviour does not have to be based on just jealousy but is the ultimate loss of control. This is demonstrated by Robert and his behaviour with the inability to accept the end of the relationship and having no contact with Daisy.
2. He ‘bombarded’ Daisy with messages, repeatedly contacted her family, called the police and her work all suggesting an attempt to regain control, ‘slur’ Daisy’s reputation and possibly in a bid for her to lose her job. Additionally, the language he used with regards to being a Civil Servant appeared to be an attempt to give some gravitas to the information he was giving, this could be further evidence of self-importance.
3. This type of behaviour is now recognised as economic abuse, the charity Surviving Economic Abuse reports economic abuse rarely happens in isolation and usually occurs alongside other forms of abuse, with 95% of cases of domestic abuse involve economic abuse. Economic abuse creates economic instability and can make the victim dependent on the abuser, isolating them even further. Someone experiencing this type of abuse can become trapped in a relationship which was evident for Daisy when she tried to separate from him.
4. These behaviours appear to demonstrate ‘Stage 5 - Escalation’ of the Homicide Timeline, his behaviour escalated with the use of manipulation to resume the relationship.
5. Robert was a ‘Rejected Stalker’[[11]](#footnote-11), 50% of all stalkers are rejected stalkers and 1 in 2 of these stalkers would carry out the threat of harm (SRP research). Therefore, rejected stalkers (Robert) are more dangerous than other types of stalkers.
6. Robert’s behaviours also suggest behaviours identified within the stalking acronym F.O.U.R[[12]](#footnote-12):

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| **F.O.U.R** | **Robert’s behaviour** |
| Fixated | Wanted Daisy back, sought revenge, wanted answers for the ending of the relationship |
| Obsessive | Obsession with the new relationship and why she ended the relationship.  |
| Unwanted | Daisy did not want contact and had blocked him.  |
| Repeated | Significant volumes of contact, inc. calls, text, emails, social media and sending flowers  |

1. In isolation these behaviours may have been considered as minimal and non-threatening but when joined together it creates a picture and pattern of behaviour which was having an impact on Daisy.
2. Each time the relationship ended Daisy’s risk escalated, Robert had been able to use behaviours to manipulate Daisy to resume the relationship. However, on this occasion, Daisy had made the decision the relationship was finally over. As a result, she changed her behaviour to be able to manage him. 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 started to use a different way to contact her and regain control. Daisy’s risk escalated when Robert realised, he was not achieving his desired outcomes.
3. Daisy’s risk escalated 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 by this, the language he begins to use also starts to dehumanise Daisy, perpetuating blame on her with regards to how he is feeling and his behaviour.
4. At this stage it suggests Robert’s thinking has moved to ‘Stage 6 – A Change of Thinking’ (Monkton Smith, 2021, pp. 163 - 174); it describes the perpetrator having feelings of revenge, injustice or humiliation that may drive a decision to resolve issues, through either moving on, revenge or potentially homicide.
5. Whilst aiming to avoid hindsight bias in reflecting on Robert’s internet searches (which no-one was aware of at the time) changing from ‘How to change locks’ and ‘How to resume relationships’ to different spyware, indicates he is shifting from reconciliation and ‘desperation’ to resume the relationship to the increase of control and jealousy.
6. Robert’s behaviour changes rapidly. His internet searches change within days from methods of stalking escalating to purchasing weapons and how to take his own life. Robert’s language within his messages to his friends start to indicate a change of thinking as he talks about killing and murder. ‘Stage 6 to ‘Stage 7 – Planning’ (Monkton Smith J. , 2021, pp. 175 - 188) are reached within a few hours.
7. Daisy moved to 1 of her children’s home which she felt was safe to do. She had also made the decision to block Robert when the stalking and abuse increased, feeling this was a safe option. Although this is understandable, as it removes the abusive behaviours towards her it increases the lack of control and power Robert had over the situation. It would therefore be beneficial to victims to have safety planning information to support them in making informed choices and understand the support available to them.
8. When Daisy called the Police, she detailed the different behaviours Robert was displaying and how she had made attempts to keep herself safe. This would have been an opportunity to go through some safety planning with her. There is value in offering domestic abuse and safety planning training not only to frontline statutory services but anyone who may experience a disclosure or witness concerns regarding domestic abuse within a work setting.
9. Within this training, practitioners would benefit from having the skills and ability to explore domestic abuse and stalking, understand its complexities, work in a trauma informed way and know the process and pathways if there is a disclosure. To support staff routine any questions within assessments need to be in a ‘language’ which will be understood, the benefit of this would enable practitioners to start open conversations, build confidence with any disclosures and be mindful of the language used within these assessments.
10. A greater understanding of the shifts in thinking and abusive behaviours may also improve victims, families, known acquaintances, friends and other bystanders in the confidence in seeking help and reduce any concern that they are overreacting to minor incidents.
11. Although at the time of Daisy’s murder Robert’s internet searches were unknown this is an opportunity for the review to highlight how abuse and stalking behaviours have changed over time and the use of online technology is now a ‘modern’ way to abuse and stalk victims. Robert demonstrated some of these behaviours, such as how to get Daisy into trouble, seeking spyware, tracking and how to resume a relationship.
12. As a response to stalking and harassment, Dorset has a Stalking Service providing an Independent Stalking Advocacy Caseworker (ISAC) service as well as a Stalking Clinic. The clinic discusses high risk stalkers and victims. The panel reviews risks to the victim, other possible future victims, interventions to the perpetrator and how to access agencies with their response.
13. In addition, stalking training is provided within the county, with the aim to be able to identify stalking typologies and risks associated with each one. However, there is no consistent offers of this training or opportunity for practitioners to continue to develop their learning.
14. Training and any assessments would benefit being updated with the use of on-line technology and ‘cyber/digital stalking’. Risk assessments used nationally are also outdated and at times not able to identify the risks posed when there is the use of technology. Additionally, safety planning and support plans need to be reviewed and updated to be able to adapt to these changes in abusive behaviours.
15. Once this training and adaptations have been completed and delivered, organisations may wish to support staff within case management and supervision to ensure their practice has developed and that they are increasing their exploratory questions, completing risk assessments and either referring and/or signposting to appropriate interventions.
16. The National Police Chief’s Council are currently carrying out a pilot of a Stalking Risk Screening Tool (SST) with 6 different police forces. To support change from these pilots the results and findings will enable continued learning and development to ensure it is embedded in practice nationally.

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| **Recommendation**1. Domestic Abuse Partnership Board to recognize the pressure on workers to attend training and support organizations in training and learning opportunities.
2. The Domestic Abuse Commissioners Office to review the Risk Assessments currently available to ensure they are up to date with the use of technology.
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**18.4 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 contact her. This is especially important when there is the likelihood of a delayed response by officers.**

1. Dorset has a domestic abuse risk pathway for victims:
* Standard Risk referrals are made to Victim Support
* Medium Risk referrals are made to the Integrated Domestic Abuse Service (IDAS)
* High Risk referrals are made to HRDA and a DAA
* Stalking service, referrals to the ISAC via (Paragon) for support (no matter the risk level)
* The Integrated Domestic Abuse Service also provides a freephone advice line.
1. Daisy accepts support at the end of the call with police, however, due to no risk assessment being carried out, being able to determine the most appropriate support would have been delayed. There was an opportunity to provide support numbers at the end of the call especially where there was a likelihood, she would not be seen in 60 minutes.
2. Even though it may have been supportive to have provided Daisy with local and national numbers and a possible referral, the timing of any of these are important. There is an acknowledgment that local commissioned services are not 24/7 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. In this case, 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.
3. Should their number be provided to all calls that were domestic abuse related, capacity would need to be considered for the local domestic abuse provider 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.
4. This concern 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.

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| **Recommendation**1. 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.
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**18.5 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, must be able to utilise the DASH questions to support their agencies assessment.**

1. Call handlers are trained to deal with all types of calls from the public, hearingmany 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 it may have enabled them to evaluate the risk, provide immediate support over the phone and ensure it supported the future decisions of the response to Daisy.
2. Throughout the call Daisy did not present as frightened and appeared to be calm throughout, at times she laughed nervously when she spoke about his behaviour. As no risk assessment was completed and considering how Daisy presented, there is a likelihood that the Police would not have been able to discern the appropriate risk level.
3. When considering the attendance criteria with THRIVE it is easy to say that Dorset Police failed to meet its target of attending this Priority 2 incident within 60 minutes, but consideration must be given to the demands on the force at the time. However, there did appear to be a cultural understanding within the call handling process that a response of 60 minutes would not be achieved therefore 3 days of availability was taken. Taking these into account it puts into question the benefit and viability of the THRIVE model and the response times.
4. With the information provided and the risk assessment conducted (not a bespoke stalking and harassment risk assessment) it may have been appropriate to categorise this message as a routine response, particularly when considering the THRIVE model with Robert was considered:
* No previous Domestic Abuse.
* No previous acts of violence.
* No direct threats.
* Victim and perpetrator living apart.
* No escalation in behaviour since the relationship ending in February 2021.
* No current intelligence regarding Robert.
1. However, without the completion of a more detailed risk assessment it highlights the gap in how risk can be determined from the limited information gained by the call. At the time to support identifying risk, the THRIVE model was used at the initial call and the DASH would only be completed when officers called or visited the victim. If a DASH had been completed with Daisy, the following may have come to light:
2. Asking Daisy if she was frightened or if she was afraid (Questions 2 and 3 of the DASH) may have indicated the impact of Robert’s behaviour on her as well as any additional concerns she had. Perpetrators who stalk their victims will in the majority not make any direct threats however the impact of their actions and behaviour can have a detrimental and terrifying effect on their victims. Daisy had never called the police previously and her family have indicated she would have only called the police if she were really concerned. “*Society’s constant dismissing and downplaying of stalking’s serious nature means victims of the crime don’t report to the police until the 100th incident, on average”* (Sheridan, 2005)[[13]](#footnote-13). It is important that police recognise if a call has been made, a victim may be concerned for their safety and welfare and require a response reflecting this.
3. Daisy made a disclosure that there was a history of following and stalking behaviour. Question 8 on the DASH explores this type of behaviour with professionals encouraged to complete the SDASH (to provide additional information to inform professional judgement). Dorset Police have incorporated the SDASH within their assessment. If Daisy had been asked these questions it may have highlighted the concerns Daisy was raising, assisted in evaluating the risk and supported any professional judgement.
4. Sending flowers and texts demonstrates behaviours associated with stalking with an apparent escalation in his behaviour since him finding out about the new relationship. Daisy’s information at this point indicates questions 10 and 11 “*is the abuse happening more often and is the abuse getting worse*” on the DASH may have been answered yes.
5. By blocking Robert, it appears Daisy felt this was positive action to take which would be understandable due to abuse she was receiving. Yet Robert may have seen this as a challenge to his control over the relationship increasing his anger towards her and the situation. This highlights the importance that when there is a disclosure to any professional including call handlers, they discuss their safety plan and the impact of any change in behaviour.
6. Daisy had never called the police before, and her family believe she only called them due to being concerned as it was so out of character for her. Victims 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 to support any risk assessment and conversation.
7. Additionally, the issue of language used within the information bar where there was both stalking and harassment noted (the information visible immediately when opened) has been highlighted as needing to reflect the most significant threat, which in this case 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.
8. 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.
9. 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).
10. 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.
11. A 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) has finally reached out for help.

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| **Recommendation**1. Dorset Police to offer reviewing officers the Homicide Timeline and Stalker Risk Profile training to help inform decisions.
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**18.6 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 something to stop, and a delay in making this happen can heighten anxiety.**

1. In the 23-hour period between Daisy reporting and the time it is known he went to her flat there were a total of 622 incidents reported to police. Of these 100 were priority 1 and 223 were priority 2. These figures are of importance; however, it is important we understand how many of the priority 1 and 2’s were in Daisy’s area, what were the custody pressures in the local area and the possible knock on effect across the force. What resilience does Dorset police have to cope with these numbers and how is this observed? The IOPC concluded their investigation with no identified actions to be made.
2. Police have advised that realistically they are unlikely to call between the hours of 22:00 hours and 0800 hours. Daisy called the police at 13:12 hours the day before she was murdered meaning the police could have called any time from 13:12 - 22:00 hours that day and again from 08:00 hours the next morning - until approximately midday before Robert was seen going to the flat and killing Daisy.
3. There was an opportunity between 08:00 hours and 12:00 hours the day of Daisys death for Police to have contacted Daisy, evaluated 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.
4. The speed in the response to Daisy not only may have been due to the volume of calls and incidents across the county but also due to the case being labelled as harassment and the subtle difference between officers’ perception of stalking as opposed to harassment.
5. As part of the review, Force Incident Managers were spoken too (their role is to monitor the open incidents and ensure attendance is speeded up if there are concerns). With the information contained within the log they indicated 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 has been reviewed by the IOPC and the Police are reviewing the processes currently.
6. Dorset Police identified the attendance criteria is not serving the purpose for which it was intended (this is 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 increase attention to calls where there is concern of domestic abuse incidents and the grading is appropriate. As per Learning Point 5, training and lessons learnt for officers have been put in place to ensure the response is appropriate to the risks identified.

**18.7 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 colleagues of Daisy and Robert. The panel and chair wish to praise the positive response from both workplaces for their support to both Daisy and Robert after the relationship ended.
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 of his intent to murder or take his own life or that he would not return to work on the Monday following his leave. 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 there was 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 the end of December 2022.
5. Domestic abuse policy and procedures need to enable staff in identifying signs of abuse and how to be able 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 work. Employees will require reassurance and full support of their employer with no repercussions to them within the workplace. 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).

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| **Recommendation**1. Domestic Abuse Partnership Board to support, encourage and raise awareness of domestic abuse workplace policies.
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**19.** **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 for the police to have explored with Daisy her relationship and the harassment and to identify risks, support her in safety planning and interventions. However, in light that Daisy did not demonstrate that 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 his friends and family. It is therefore imperative to raise awareness campaigns and to continue and evolve with new and emerging trends and behaviours.
5. This review has highlighted 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 3rd 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.







**DHR14 ACTION PLAN**

Whilst a number of actions are marked as ‘complete’ at the time of finalising this report, learning from DHRs is a continuous and ongoing process. In this regard, Dorset CSP will continue to review past Action Plans with a view to identifying new as well as adding to past developments rather than repeating actions in isolation.

| **Recommendation** | **Scope of recommendation i.e. local or regional** | **Action to take** | **Lead Agency** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Date of completion and Outcome** |
| --- | --- | --- | --- | --- | --- | --- |
| What is the over-arching recommendation?  | Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)  | How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?  | Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?  | Have there been key steps that have allowed the recommendation to be enacted?  | When should this recommendation be completed by?  | When is the recommendation actually completed? What does outcome look like |
| Dorset's Domestic Abuse Strategy provides the foundation for and are to develop how they will:• Review the effectiveness of awareness campaigns, in terms of: impact, partnership working, engagement with the community and involvement of the community in design and delivery. • Identify the mechanisms for the inclusion of the voice of survivors in the development and delivery of Dorset's DA work• Review awareness raising information and materials relating to stalking and associated risks, considering accessibility of language to the public, and revise accordingly | LocalLocalLocal | DAPB to collect data to identify increases of referrals and referral sources.Contact with participants 6 months after receiving training to identify if there has been a change in practice.Create a survivor forum which is led by ‘Experts by Experience’ A representative from the forum to attend the DAPB.DAPB to work with services and survivors with any awareness campaigns to ensure it is coproduced and coordinated. | Dorset CouncilDorset Council and training providerDorset CouncilDorset CouncilDorset Council | Data will be collected as part of the new Domestic Abuse Act for the DAC. Commissioned services also provide data regarding referrals Work with current Domestic Abuse Forum is already in place and may be able to assist in the creation and development of this.**Update July 2023: Work around system design that is currently being done, along with the DA Research project will contribute to these actions**Dorset council and local services currently distribute material to raise awareness.**Update July 2023: Paragon have been funded to deliver their Dragonfly, which now incorporates a specific stalking element. Also, related to a different DHR, Children’s Services have developed and are delivering training to staff and young people that includes specific content relating to stalking.**  | 1/4/202331/3/20241/4/20231/4/20231/4/2023 | **COMPLETE** **July 2023****COMPLETE** **July 2023****COMPLETE** **July 2023** |
| Dorset Health Care to ensure intrafamilial abuse and how to identify possible disclosures of domestic abuse by male victims is included as within the Aims and Objectives of the planned future training package. | Local | Any training provided ensures intersectionality, protected characteristics and marginalized groups are included within the training.Tools and information is provided within the training to enable practitioners to identify these victims. | DHC and commissioned DA provider | **Update July 2023: DCH have reviewed their training in line with these actions, and can mark this complete for them.** | 1/4/2023 | **COMPLETE** **July 2023** |
| Dorset Council to provide a detailed and varied annual training calendar for practitioners. | Local | DAPB to work with local and national services to create a training portfolio available to professionals via the council website | DAPB | Training is currently available via the council website, this is to be developed to ensure it is coordinated, varied and continually up to date.**Update July 2023: There is potential to consider linking this action with other work to collate and share a list of various training and resources available through all partners.**  | March 2023 (and then annually) | **COMPLETE** **July 2023** |
| The Domestic Abuse Commissioners Office to review of the Risk Assessments currently available to ensure they are up to date with the use of technology. | National | DAC to work with National and local stalking and tech specialists as well as survivors to create a refreshed risk assessment.  | Domestic Abuse Commissioners Office | **Update July 2023: There is an opportunity to raise this through scheduled meetings between regional DAC advisor and the community safety team.**  | March 2024 | **COMPLETE** **July 2023** |
| Further development of case-management, supervision and personal development processes to improve the impact of and monitoring application of learning from domestic abuse and stalking training received. | Local | Case management and supervision policies to be revised and include review of domestic abuse cases and support for staffSupervision and case management records reflect oversight of domestic abuse, actions and follow up.All domestic abuse cases to be supported with a DASH and evidence of any conversations and actions and/or signposting to specialist support providers. | All panel membersAll panel membersAll panel members | **Update July 2023: Dorset Council Adult Services are undertaking some work around their supervision policy, with consideration to the Council’s policy,. This includes supervision records, case-management, CPD and Wellbeing. Conversations are also taking place with Children’s Services around their practice, which includes evidenced reflective practice.**  | April 2023April 2023April 2023 | **COMPLETE** **July 2023** |
| To approach the Regional Office of the DA Commissioner to understand that impact of the changing demands on providers, and sufficiency of funding to respond. | National | Dorset to collect data and evidence to provide the Regional DAC for the need for additional funding. | Dorset Council and DAC | Data is collected currently with the commissioned providers and under the requirement within the Domestic Abuse Act.**Update July 2023: There is an opportunity to raise this through scheduled meetings between regional DAC advisor and the community safety team.** | April 2023 | **COMPLETE** **July 2023** |
| Dorset Police to offer reviewing officers the Homicide Timeline and Stalker Risk Profile (SRP)training to enhance informing decisions | Local | This external training to be considered as part reviewing officers Continual Professional Development. | Dorset Police | Stalking SPOC within Dorset Police has completed SRP training.**Feb 2023**Access to the training has been secured**Update July 2023: This training is available, and with a relatively small number of reviewing officers in the force, it is a smaller number to train.** | April 2023 | **COMPLETE** **July 2023** |
| Dorset Council to provide the Employers Initiative on Domestic Abuse (EIDA) website link on their Domestic Abuse page to support with workplace policies and procedures. | Local | Update Domestic Abuse Website and pathway with the EIDA website link | Dorset Council |  | March 2023 |  |

1. <https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a> [↑](#footnote-ref-1)
2. <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews> [↑](#footnote-ref-2)
3. <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022> [↑](#footnote-ref-3)
4. <https://www.dorsetcouncil.gov.uk/-/domestic-homicide-reviews-dhrs> [↑](#footnote-ref-4)
5. The suicide note was never sent and found by police after Robert’s death. [↑](#footnote-ref-5)
6. <https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted> [↑](#footnote-ref-6)
7. Previously coercive controlling behaviour could only occur if in an intimate relationship, there was an intimate relationship, but the persons remain living with each other, or they are family members. [↑](#footnote-ref-7)
8. <https://www.theduluthmodel.org/wheels/understanding-power-control-wheel/#minimizing> [↑](#footnote-ref-8)
9. <https://www.researchgate.net/publication/259905459_A_Typology_of_Domestic_Violence_Intimate_Terrorism_Violent_Resistance_and_Situational_Couple_Violence_by_Michael_P_Johnson> [↑](#footnote-ref-9)
10. <https://www.gov.uk/government/publications/tackling-domestic-abuse-plan> [↑](#footnote-ref-10)
11. <https://www.stalkingriskprofile.com/> [↑](#footnote-ref-11)
12. <https://veritas-justice.co.uk/stalking/> [↑](#footnote-ref-12)
13. <https://equation.org.uk/stalking-facts/?msclkid=b4beb2cfceaa11eca5b7bb7589aeb0a0> [↑](#footnote-ref-13)