DHR OVERVIEW REPORT INTO THE MURDER OF MIRIANA, AUGUST 2015

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It's important to remember that Albania was an isolated country for so long. Even after explaining the system to women, they don't understand what Social Services is, they don't know what other agencies do. Say we'll make a referral to Social Services, women don't know what that is. It's a different culture. There all these different nationalities in London, and of course you can't have a service for everyone. But [Albanians] are new to the world here. It's not like there are generations of Albanians here. Knowing what services are available, what are your options, I don't think any woman in Albania would think there's a refuge to help.

Albanian Domestic Violence Support Worker

Glossary

CSC: Children's Social Care
CSP: Community Safety Partnership
DHR: Domestic Homicide Review
ICU: Intensive Care Unit
IDVA: Independent Domestic Violence Adviser
IMR: Individual Management Review
LB: London Borough
LNWHT: London North West Healthcare Trust
MARAC: Multi-Agency Risk Assessment Conference
NSPCC: National Society for the Prevention of Cruelty to Children

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Preface

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Miriana, and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. She is joined by the Review Panel, in thanking Jane Medici for the efficient administration of the DHR and Mirkena Shqarri-Palluqi and the Empower Project for their expert information on Albanian women and domestic violence.

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that 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;

with a view to identifying the lessons to be learnt from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013. This can be found in full at Appendix B.

1.2 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- 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 these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order 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.

1.3. This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Miriana who was murdered in August 2015 by her husband, Erag. The decision to undertake a DHR was made by Hounslow Community Safety Partnership in consultation with local specialists. The Home Office was duly informed. The Panel met for the first time in December 2015 where IMRs were commissioned and agencies advised to implement any early learning without delay. In consultation with the Senior Investigating Officer, it was decided that the DHR could run in parallel with the criminal investigation and four further meetings were subsequently held in January, February, March and June.

1.4. Domestic violence is a key priority for the Hounslow Community Safety Partnership. The 'Keeping you safe' priority in the Corporate Plan 2014-2019 makes specific reference to domestic violence: '*support people at risk of domestic violence to seek help and ensure they are kept safe'*. In addition to this, the Hounslow Community Safety Strategy 2014-2017 outlines its commitment to applying a partnership approach to tackling domestic violence in the borough.

There are a range of domestic violence services in Hounslow. These include the Hounslow Domestic and Sexual Violence Outreach Service which provides crisis intervention support to all domestic violence victims as well as supporting victims of rape and sexual violence. A pan-London Independent Domestic Violence Adviser Service (IDVA) is also provided by Victim Support and there is a specific Health IDVA based in maternity services. There is also a One Stop Shop that offers a single point of contact where victims of domestic and sexual violence can attend to receive free support and advice from a variety of services/agencies. The services offered include IDVAs, Police, Solicitors, Housing, Refuge, NSPCC, Homestart and iHear (Drug) Partnership.

The Sanctuary Scheme provides victims the opportunity to stay safely within their home, with the installation of additional security measures. The only criteria is the perpetrator is no longer living in the home. This option allows victims and their children to stay safely in their own properties without having to be re-housed.

In addition to this, the local authority also offers a therapeutic group work programme for children who have been affected by domestic violence, with a parallel group for their mothers. The Council also has a dedicated domestic violence prevention education programme delivered in schools, teaching children and young people about respectful relationships and an annual public awareness campaign is run across the Borough.

The Community Safety Team manage the monthly Multi-Agency Risk Assessment Conference (MARAC) and also commissions Refuge to provide a women only accommodation based service, for victims and their children fleeing domestic violence.

2. Overview

Persons involved in this DHR[1]

Name	Gender	Age at the time of the	Relationship with victim	Ethnicity

[1] All names in the table are pseudonyms

		murder		
Miriana	F	33	Victim	Albanian
Erag	M	40	Husband and perpetrator	Albanian
Luan	M	7	Son of the above	Albanian
Bari / alban	M	11	Son of the above	Albanian

2.1. Summary of the case:

Miriana was strangled at her home in LB Hounslow. Her husband of 13 years was jailed for manslaughter in March 2016. He received a sentence of 10.5 years. Both parties were Albanian.

The couple had two sons aged 7 and 11. The children were asleep when the murder occurred and were unaware of events elsewhere in the house.

Agency contacts were mostly limited to a child protection investigation which took place some eight months before the homicide. This had resulted in both Mariana and Erag attending a parenting programme. There was no known history of domestic violence although friends did know that the marriage was unhappy and described some elements of controlling behaviour. However, they were not familiar with the concept of coercive control and did not see this as potentially dangerous. This had become significantly worse subsequent to the child protection investigation and Mariana beginning a platonic friendship with another man.

The family lived in LB Hounslow, but the children went to school in LB Ealing and the family received health services in both Boroughs.

3. Parallel reviews

There was a criminal trial which resulted in a sentence of ten years and six months for manslaughter rather than murder due to loss of control. An appeal is being considered.

The day after Miriana died, a special post mortem took place at Hammersmith and Fulham mortuary conducted by Home Office pathologist, Dr Chapman. The cause of death was recorded as compression of the neck causing bruising and fractures as a result of severe pressure as well as bruising consistent with having been punched, kicked or from knee pressure. She had also been bitten a number of times and a specialist concluded the marks to her back and arm had been caused by Erag.

An inquest was opened by Her Majesty's Coroner, and was adjourned pending the outcome of the criminal trial. Contact was made with the Coroner and a copy of the report will be passed to him post Home Office approval.

A Serious Case Review was considered but felt to be unnecessary as the children were asleep at the time of the incident and have subsequently confirmed that they did not hear or see anything. However, safeguarding issues in relation to the children were thoroughly considered within the DHR terms of reference and subsequent agency reports.

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following agencies:

- Hounslow CCG
- Hounslow Domestic and Sexual Violence Outreach Service
- Hounslow Public Health
- LB Hounslow Children's Social Care
- LB Hounslow Community Safety Team
- Metropolitan Police
- North West London Hospital Trust
- Refuge

5. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. Davina James-Hanman is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence.

All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. In summary, these were as follows:

1. Each agency's involvement with the subjects of the Review.
2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Miriana:

(a) Communication between services

(b) Information sharing between services with regard to the safeguarding of children

3. Whether the work undertaken by services in this case was consistent with each organisations':

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Miriana, her husband or their children, concerning domestic violence or other significant harm from 2002[2] onwards until the point of the death. It will seek to understand what decisions were taken

[2] Later revised to 2013

and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Miriana and Erag.

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies ' ability to respond effectively.

10. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

6.2. Agencies were originally asked to search their records from 2002 onwards which is the year that Miriana arrived in the UK to join Erag on a marriage visa. A paucity of findings led the Panel to revise this to 2013 although significant events outside this scope were still considered.

7. Confidentiality and dissemination

7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication, by the Home Office Quality Assurance Panel.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

8. Methodology

8.1. The agencies listed below submitted an IMR:

- LB Hounslow Children's Social Care
- Early Intervention Service
- London North West Healthcare Trust (LNWHT)

8.2. In addition, short reports were provided by:

- Safeguarding Hounslow & Richmond Community Healthcare
- Metropolitan Police
- Care UK
- Belmont Medical Practice

A further five agencies advised they had not had any contact with any family member.

Minimal contact was reported by another two agencies.

Agencies completing IMRs and reports were asked to provide chronological accounts of their contact with Miriana and/or Erag and their children prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. The DHR has focused on the contacts of agencies from 1st January 2013 to August 2015 but also includes relevant information prior to that period. The recommendations to address lessons learnt are listed in section 13 of this report and an action plan to implement those recommendations are catalogued in Appendix C.

Each IMR was scrutinised by the Panel and in some instances the report was redrafted to take account of questions raised.

The Review Panel has checked that the key agencies taking part in this Review have domestic violence policies and is satisfied that where these exist, they are fit for purpose. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) of participating agencies
- The Police Senior Investigating Officer
- The criminal trial and associated press articles
- DHR Panel discussions
- Information from friends, family and employer
- Expert testimony from The Empower Project[3] on Albanian women and

[3] This was a partnership between Solace and Shpresa

domestic violence. This was later supplemented with the evaluation report of the project.

The Community Safety Partnership is responsible for monitoring the implementation of the action plan.

8.4. The Panel were extremely grateful to Mirkena Shqarri-Palluqi, a former case worker on the Empower Project. The information below is a combination of her presentation and the evaluation of this project.

Although migration from Albania to the UK has been documented throughout the 20th century, the 1991 census recorded just 338 Albanians known to be living in England. Conflicts and persecution following the breakup of the former Yugoslavia led to 'the first generation' of an Albanian community in the UK, which grew steadily during the 1990s, but no precise figures exist.

The most recent census data records 13,415 respondents whose country of birth was Albania, with just over half (52%, n=7,009) living in London. Twice as many people (28,446) gave their country of birth as Kosovo, with three quarters (76%, n=21,516) living in London. There is limited information about the gender breakdown of the Albanian community in the UK, but it has been estimated that initially around two thirds were young men. Later work suggests that a 'family amnesty' may have levelled out this imbalance.

Changes in the political regime in Albania have also shaped the status of women, with implications for women who migrate to the UK. The post-war communist government sought to achieve equality for women in education and employment, with limited progress in that while women's employment levels increased, it was concentrated in 'female' professions and at the lowest ranks. These advances were reversed after the collapse of communism, as gender equality became associated with a discredited regime, and women were pushed back into the home. Discrimination remains evident, with a continued anchoring of women through family responsibilities which entrenches financial and social dependence on men. Motherhood is central to constructions of womanhood; women are expected to put their needs last and to obey their husbands.

It is therefore unsurprising that Albanian women report living in the UK as 'liberation', particularly valuing the possibility of economic independence. However, the gendered patterns of migration from Albania affect how women arrive in the UK and everyday life once here. Few women migrate independently, as men typically make these life-changing decisions. As such, most Albanian women in the UK are wives. Few speak English or work outside the home and in this regard Miriana was unusual in doing both.

Research by King et al (2006) noted that Albanian families in London have reproduced unequal household gender relations. However, to what extent this differs from households in majority communities is not explored.

There is a limited knowledge base on violence against women in Albania, but key findings include:

- prevalence surveys indicate that half of women aged 18-55 in Albania have experienced domestic violence in the last 12 months;
- the vast majority of women do not seek support from formal agencies;

- Albania is the top country of origin for women identified as potential victims of trafficking into the UK.

Recognition of violence against women as cause and consequence of gender inequality was driven by women's organisations in Albania during the social changes of the 1990s. Currently there is a national strategy on Gender Equality and Domestic Violence. A 'Law on Measures Against Violence in Family Relations', introduced in 2007, was followed by a significant increase in reporting, as women became more confident that action would be taken. The focus of research and policy is on domestic violence, although trafficking of Albanian women for sexual exploitation has also attracted international attention.

The most recent prevalence survey indicates that over half of women aged 18-55 (53%) reported experiencing domestic violence in the last 12 months, with a slightly higher proportion (59.4%) having ever experienced violence from intimate partners. This is higher than for women living in the UK. Men from rural areas are more likely to be abusive to their partners, possibly related to norms about a man's right to exert control over his wife, and weaker sanctions. Suspicions of infidelity on the part of women are widely seen as justification for homicide.

Women's help-seeking behaviour also demonstrate the challenges associated with providing support to Albanian-speaking women. Fewer than 1 in 10 women had sought help to cope with or escape violence, and mirroring research from the UK, the vast majority (90%) turned to family. However, family cannot always be relied on to provide support or protection; it is common for women to be blamed for any marital difficulties and seeking help from outside the family is frowned upon.

Divorce remains women's preferred option to escape violence, rather than criminal or civil proceedings. Studies consistently note that domestic violence is currently perceived to be normal and inevitable in Albania.

8.5. Involvement of family and friends

The family of the victim were informed about the commencement of the DHR and invited to participate but chose not to be involved.

Two friends of the victim and a cousin did, however, choose to participate and the Review Panel is immensely grateful for their insights. Miriana did speak more openly with her two friends about her marriage than with her cousin but even here, it was never detailed or at length.

A short conversation was also had with Erag's employer; calls to Mariana's employer were not returned.

The perpetrator was contacted three times; once through his solicitor and no response was received. He was then contacted twice through his Offender Manager, once pre-trial and once afterwards. He declined to participate on both of these occasions.

The Panel agreed that post publication, a full and un-redacted copy of this report would be placed on the files of Miriana's two children so that should they come seeking information later in life, it would be available to them.

9. Key events

August 2003: Erag was believed to have been involved in a 'damage only' road traffic accident and denied being the driver. Keys to the vehicle were found in his possession along with documents relating to the vehicle. He was charged with driving with excess alcohol and driving not in accordance with a licence

May 2004: Erag was arrested for theft (shoplifting) and received a reprimand.

April 2009: Bari is seen at Ealing Hospital orthopaedic clinic for a fractured wrist. The cause of the injury is not recorded.

November 2009: Erag was stopped by police as he was suspected of being involved in anti-social behaviour. No further action was taken.

May 2012: Luan is seen at Ealing A&E reportedly after falling off an exercise machine. He sustained an angulated fracture of his wrist which required manipulation under anaesthetic.

November 2012: The universal School Nurse health questionnaire is completed by Mariana for Luan. Nothing of note is recorded.

March 2013: Miriana takes Bari to Ealing walk-in medical centre with wrist pain sustained during a game of football. He is prescribed rest and analgesics.

June 2013: Bari is seen at Ealing A&E with an injured wrist (soft tissue injury). Cause is recorded as occurring during a game of football.

June 2013: Luan is seen at Ealing Urgent Care Centre regarding an injury to forehead whilst running with his eyes closed into a metal pole. He was treated for a superficial laceration and was given head injury advice.

December 2014: Luan disclosed at school (which is in the neighbouring Borough of Ealing) that he had been locked out of the house by Erag the previous evening because he was up late looking for a toy. Miriana found him and took him back inside. Luan described feeling frightened, that his father hits him with his hands on his cheek and sometimes uses a rope and 'a stick thing' to hit him on his body and face. Luan disclosed that his brother, Bari, is also hit. Luan was visibly distressed when speaking to the teacher. He had no visible bruises or injuries. Children's Social Care were informed, a strategy discussion was held and a joint Section 47 Child Protection Investigation initiated. Luan and Bari were interviewed separately at school by a Social Worker. Luan did not want to return home to Erag but was happy to return if his father was not there. Bari disclosed that both he and Luan are smacked by their parents when they are naughty. Bari was aware that his parents had argued the previous night about something to do with Luan and described it as a 'moderate argument'. Bari was happy to return home.

The Section 47 investigation continued with a visit to the family home the same day by a Social Worker who was later joined by a police officer from the Child Abuse Investigation Team.

Miriana, Luan and Bari were present. Miriana was informed of the disclosures and refuted that Luan had ever been hit by Erag. Luan directed them to a dressing gown cord and a rolling pin. Miriana asked Luan why he was lying. Miriana signed a written agreement not to discuss the disclosures with the children. Upon leaving and while outside the front door, the Social Worker heard Luan say 'please don't mummy, I didn't'. The Social Worker knocked, informed Miriana of what she'd heard and asked to see Luan. Miriana denied that

she had done anything to Luan and that he was fighting with his brother. She would not allow the Social Worker to enter the property. Meanwhile, Erag was arrested and bailed not to attend the property or to have direct or indirect contact with the children. The police returned to the property later that evening to check on the children.

All relevant parties are notified except School Nursing.

Seven days later, the Section 47 investigation concluded that the concerns were substantiated but assessed that there was not a continued risk of significant harm. Erag accepted that there had been historical incidents of physical chastisement but minimised the concerns. During the investigation, Luan confirmed that Bari was hit by Erag on occasions for 'not listening'. Luan also reported that Miriana had also smacked the children on occasion for not completing homework, Miriana denied this and Bari stated that he was not hit by his mother. Both parents agreed to work with Children's Social Care and Miriana had been observed to have a warm and loving relationship with the children.

The same day, Erag attends his GP and requests sleeping tablets.

The Social Worker makes two visits to the family home over the next four days. On the second of these, there is observation of contact between Erag and his children which is assessed as positive. Prior to his arrival, both children informed the Social Worker that they wanted to see him and wanted him to return home.

No further action was taken by the police as the child was distressed by his father's arrest; there was no medical evidence and both parents were co-operating with Children's Social Care. Bail conditions are not renewed and Erag is able to return home thirteen days after Luan made the disclosure.

In early January 2015, approximately two weeks later, the Head Teacher at Luan's school calls Children's Social Care concerned that Luan appeared scared and unwilling to speak with her. The Head Teacher was concerned that the children may not make further disclosures which may impact on their safety. The Social Worker agreed to undertake home visit.

The following day another call was received from the school reporting that Luan had a graze on his knee which he said was from playing football in the house and that he then showed other marks on his body but wouldn't say how he got them.

A home visit was undertaken by the Social Worker following this information being received and Luan was spoken to. However, there were no concerns identified. Children's Social Care continued with further assessments in light of the parent's lack of insight and the father (Erag) appearing to minimise the allegations.

Between January and early April, a Child and Family Assessment is completed and reviewed by a manager. It is agreed that a Child in Need Plan should be put in place. During the course of the assessment, Luan spoke positively about Erag being back at home and no further reports are received of physical chastisement. The school confirmed that the children's behaviour was very good and that they had no new concerns.

Both Miriana and Erag agreed to engage with services and to access parenting support. They were referred to the Early Intervention Service and allocated a place in April. It was suggested that Erag self-refer to an anger management course but he declined as he didn't consider this necessary. Erag reported that this was the first and last time physical chastisement had been used and Miriana agreed. This contradicts his earlier admissions.

Around this time, Miriana became friends with another man. Both parties texted each other significantly (1900 times) at times when either she was at work or Erag was out of the house at work.

Although this friendship was purely platonic, Erag found out and was suspicious and disbelieving. He began to monitor her phone and stopped her from accessing Facebook. He insisted she leave a job she seemed to enjoy and became increasingly jealous. He told others that he was unhappy with his marriage, as did Miriana. She told friends that nightly rows would erupt after the children had gone to bed and that he seemed particularly obsessed with the fact that her platonic friend was Asian.

In April, Erag was told he was to be made redundant. He attributed the loss of his job to having to inform his employer about the involvement of Children's Social Care as he needed to take time off work to attend parenting classes.

In May, Erag visits his GP and reports worsening insomnia and a depressed mood. The GP recorded that Erag was tearful and broke down. Erag told his GP that his son had told his teacher that his father hits him. As a result Children's Social Care were involved. Erag told the GP that he didn't hit his children and the child's nature would be to say anything if he could get ten minutes on the computer. Erag also told his GP about the parenting classes, saying that whilst there were useful things, he is surrounded by other parents who are drug addicts and long term depressed people. Erag said he was not enjoying life unless it related to being with his children, he had poor concentration, poor appetite, was losing weight and was sleeping poorly. He further reported that he did have suicidal thoughts but said would never act on them due to his family. He had also recently received news that he was to be made redundant in six weeks. He was signed off sick for two weeks and prescribed further sleeping tablets.

In June, Children's Social Care close the case following a report from the Parenting Programme that Erag and Miriana have attended all sessions and completed the tasks set for them so far. In the view of the programme worker, the family needed no further input as they were implementing the strategies advised on the parenting programme.

In July, the parenting programme finishes. Erag and Miriana continued to attend to the end even though Children's Social Care had closed the file earlier. This is interpreted as them being genuinely engaged. Records indicate that both parents worked together very well and were fully engaged on the programme. They completed all the tasks required of them and were always ready to give their feedback to the group in line with the programme objectives. During the last session, all parents were asked to reflect on the sessions and feedback to the group how they had found the process. Miriana said that at the beginning of the group she felt strange but felt that she could now control her anger. She also said that having attended the group, there was a silver lining from the incident that brought them to this group in the first place. Erag said that he had enjoyed the group and named some specific exercises that he had found useful. Out of the 18 participants who completed the course, Miriana and Erag were recognised as the 'family star' for their attendance, punctuality and general input.

In early August, Miriana tells a friend she is planning on making her husband a cake for his birthday. Despite her unhappiness with the marriage, she seems to be trying to make it work. She tells her friend that she felt trapped by convention; that it was 'her lot' to make it work. She also made a vague suggestion that she may seek a divorce when the children were older and needed her less. Erag had been clear that if she sought divorce now, he would not permit her to take both of the children. The friend added that Erag called her constantly to find out her whereabouts in the days leading up to the murder and

that Miriana seemed worried about Erag's reaction if she was late home. Concerns about Erag's reaction wasn't usual for her.

The night before the murder, Erag is seen in Ealing A&E with complaints of chest pain. He discloses drinking alcohol frequently. Based on CCTV and phone records, Miriana collected him from the hospital at around 2am. As the children were asleep, this would have necessitated leaving the children alone in the house for approximately 25 minutes. At the hospital, Erag gave a different residential address which later enquiries would prove to be where the family had previously lived. It has not been possible to determine why Erag did this.

On the night of the murder, at 1.10am, Erag called the police and stated *'I think my wife is dead'*. He said that Miriana had attempted to strangle him and he defended himself and strangled her back. He also alleged that she had come at him with a knife but later admitted that he had fabricated this and placed the knife after she was unconscious. He said later that they had been arguing about divorce and the stigma of this.

Erag informed the police that the couple's two children were asleep in the address. They were unaware of what had occurred.

Police attended and found Miriana unconscious on the floor and the officers gave immediate first aid. She was taken to Ealing Hospital where she died as a result of her injuries at 20.00 hours.

Erag was arrested for murder and was transported to Hounslow Police Station. He collapsed as he was being led from the police van and CPR (Cardiopulmonary resuscitation) was commenced. Erag responded almost immediately and was taken to West Middlesex Hospital and checked before being released to police custody.

The children were taken into Police Protection.

10. Analysis

The Individual Management Reviews have been carefully considered through the view point of Miriana, to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has deliberated if all of the lessons have been identified and are being properly addressed.

The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

The authors of the IMRs and Reports have followed the Review's Terms of Reference carefully, and addressed the points within it that were relevant to their organisations. They have each been honest, thorough and transparent in completing their reviews and reports.

10.1. Each agency's involvement with the subjects of the Review.

This is detailed in the chronology above.

10.2. Whether an improvement in any of the following might have led to a different outcome for Miriana:

(a) Communication between services and, in particular, between services in different London Boroughs;
(b) Information sharing between services and, in particular, between services in different London Boroughs;
(c) Joint assessment, decision-making, intervention and monitoring.

Almost all information was appropriately shared between agencies including across Borough boundaries. There was evidence of good joint agency working and appropriate interventions made.

There were two exceptions: Firstly, the failure to notify the School Nurse. This was because an assumption was made that any information School Nurses may have would be recorded in GP notes.

The second exception was that information about Erag's worsening insomnia and depression in May 2015 should have been shared by the GP with Children's Social Care given that their investigations were ongoing at this point.

10.3. Whether the work undertaken by services in this case was consistent with each organisations':

(a) Professional standards;
(b) Domestic violence policy, procedures and protocols; and
(c) Whether these standards, policies, procedures and protocols are consistent with current best practice and what more could have be done to increase access and take up.

All agencies worked within their professional standards and existing policies.

Children's Social Care noted in their IMR however, that the case records did not fully reflect the extent or quality of the work undertaken by practitioners. A recommendation has been made on this matter.

LNWHT also noted in their IMR that as of 2014 there is a plan by Ealing local authority to reduce school nursing services in Ealing by 50% over a three year period, This will have major ramifications for school nurses and their ability to respond to the high demands in partnership plus cases. Ealing has the highest number of children subject to Child Protection plans in the North West London health care setting.

10.4. The response of the relevant agencies to any referrals relating to Miriana or Erag, during the period covered by this Review concerning domestic violence or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact within the period covered by this review onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Miriana and Erag

Although outside the scope, the Panel did make enquiries about the routine screening that Miriana may have had when pregnant. The first pregnancy occurred prior to the introduction of routine screening and no record could be found of Mariana being screened in 2007/08 when pregnant with Luan. Today, routine screen is more embedded and all pregnant women are given a time alone appointment where sensitive questions are asked in a safe environment. There is an Independent Domestic Violence Adviser based at the hospital every Wednesday, linking in with maternity services.

There was evidence of timely and robust decision making with regard to Luan's disclosure at school as detailed in the chronology.

No agency was aware of any domestic violence and as such, no risk assessments or domestic abuse interventions took place. Nevertheless, as part of her assessment of risk during the Child Protection Investigation, the Social Worker asked Miriana whether there was domestic violence in her relationship with Erag, as well as exploring whether substance misuse or mental health issues were risk factors, and Miriana replied that there was not. The Panel felt that given Erag's presenting issues, (insomnia, depression, some suicide ideation, alcohol use and the involvement of Children's Social Care) that Erag should have been screened for domestic violence by his GP and at the hospital.

10.5. The training provided to child focussed services to ensure that, when the focus is on meeting the needs of a child, the welfare of adults is also a significant consideration.

The Panel is satisfied that such training is in place.

10.6. Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.

The thresholds for child protection were appropriately applied.

As there was no domestic violence of which agencies were aware, thresholds did not apply.

10.7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of those involved and whether any special needs were explored, shared appropriately and recorded.

The initial referral from the children's school identified that the family were Albanian, that their religion was Muslim, and that the parents' first language was Albanian but that they did not require an interpreter for written correspondence or direct communication. The Social Worker observed that both Miriana and Erag were able to communicate fluently in English and did not require an interpreter. The family appear to have communicated with each other in English rather than Albanian, and the Social Worker understood that while Bari knows some Albanian, Luan is not able to understand it.

The Strengthening Families parenting programme is written by the Race Equality Foundation and the basis of the programme starts from an individual's ethnic, cultural, family and spiritual roots. Of the five core components, one is cultural and spiritual and so the programme fully meets the need of all attendees in terms of their heritage and diversity.

LNWHT noted in their IMR that there were difficulties locating family members in Albania after Mariana was admitted to the ICU. A friend was in attendance and met with the consultant following the death but the records do not reflect the extent of the meeting nor any conversations that took place.

All nine protected characteristics in the 2010 Equality Act were considered by the DHR Panel. Several protected characteristics were found to have relevance to this DHR. These were:

Age: Miriana was only twenty when she moved to a different culture to get married.

Marital status: Miriana and Erag were married although it was not a happy relationship. Miriana told friends that she intended to divorce when the children were older. It is possible that Erag sensed this and sought to restrict her capacity to leave him by exerting control over her social networks and insisting that she leave her job.

Ethnicity: Miriana and Erag were both of Albanian origin. It is worth noting that the evaluation of the Empower Project, a specialist service for Albanian women, found that introducing discussions about domestic violence into their work was met with some initial scepticism and resistance. Some women reported fearing that they would be 'betraying' the community if they spoke out about violence.

Miriana was unusual among Albanian women in being able to speak English; in the Empower Project, only 16% of their clients did so. Miriana also wrote rudimentary English, writing on her Facebook page in both English and Albanian.

The centrality of motherhood to Albanian women means that concern for children can be a route to encourage women to seek support. However, this requires careful balancing, since it can send a message to women that the children matter more than they do, and mentioning the possibility of losing children if they do not leave may scare women into denying that violence is happening.

Albanian women have grown up with men's right to dominate; there is an assumption that women live with violence, including rape, since men have an entitlement to their wives' bodies.

Sex: Sex is also relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed[4]. Latest published figures show that just over half of female victims of homicide in the UK aged 16 or over had been killed by their partner, ex-partner or lover (54%). In contrast, only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover.

With respect to the agencies involved in this review, no IMR found that any of the protected characteristics impacted on the services delivered.

[4] Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

10.8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

There was appropriate management oversight in all of the key agencies.

10.9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

As noted above, there are concerns with regard to the reduction of the School Nursing Service but this did not impact on the case.

10.10. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

Friends were aware that the marriage was unhappy but were not aware of any abuse. They were not familiar with the concept of coercive control and did not see this as potentially dangerous.

10.11. Whether the agencies had in place policies and procedures for safeguarding and promoting the welfare of children in relation to domestic violence and whether there were any failings in the policies and procedures themselves, in the implementation of policies and procedures, in management oversight or in compliance with policy and procedures.

Based on what information was known at the time, it does not appear that even if a domestic violence risk assessment had been completed that this would not have identified a high level of risk. Both parents (who were seen separately as well as together) described their relationship as being 'loving and supportive'. The Social Workers observation was that Miriana presented as the more outspoken and dominant character, and that Erag presented as being quieter and more passive, seeming to 'do was he was told'. Miriana informed the Social Worker that she loved her husband very much, that she found it difficult to believe that he had physically chastised Luan and that she had never seen any form of violence in the family home (despite Erag acknowledging that he had hit the children on occasion as a way to manage behaviour). The children were asked about their relationships with their parents and what they most liked and disliked about members of the family; neither reported concerns in relation to domestic violence nor shared any information with the Social Worker to give cause to be concerned that domestic violence may be a feature in the parents' relationship. The Social Worker also spent time in the family home observing interactions and building relationships and during this time did not make any observations that gave cause for concern about possible domestic violence.

As such, while the Social Worker gave consideration to a range of potential risk factors including domestic violence within the course of her work with the family, the need did not arise for a specific course of action to be initiated in relation to concerns about domestic violence because of an absence of information to indicate this was a concern.

This was also echoed in the observations of the workers from the Parenting Programme. They saw that Erag and Miriana worked well together, and they complimented each other when feeding back to the rest of the group. Both facilitators did not observe any conflict or disagreements that gave them any cause for concern. There was no evidence of any controlling behaviour throughout the course.

10.12. How well the needs of, and potential risks to, the children involved were identified by all agencies and how well were the child and the parents engaged in this process. In particular the Review will explore whether the impact of domestic violence on the children was recognised and appropriate action taken to respond to their needs in the light of what was known by any agencies about domestic violence that was occurring in the household.

Overall, expected standards were met. There is a question about whether Miriana and Erag were entirely honest with professionals during the course of involvement about the use of physical chastisement in the family home. Both parents denied any awareness of the other using physical chastisement on the children, despite the children's disclosures and Erag accepting that he had done so. While it could be suggested that the Social Worker could have offered more challenge around this, ultimately both parents agreed that they would benefit from intervention in relation to parenting to learn how to better manage the children's behaviour. They engaged well with the intervention and seemed to have made changes which were evidenced in the children presenting as being happier and less emotional.

On the basis of what is known, it is not possible to attribute the concerns about the children's presentation to exposure to domestic violence. It is known that there were concerns about aspects of the quality of parenting they received, specifically in relation to physical chastisement, and that Luan in particular appeared fearful of what social work involvement may mean for his future care (in other words, a fear that he might be removed from his parents). Both children were able to talk to the Social Worker about who they would tell if they had worries (both identified school staff) and through the course of intervention the Social Worker considered that the children were likely to make disclosures if there were incidents of further physical chastisement. During the course of the Social Worker's intervention with the family, the children were observed to be happy and relaxed in the home with both parents. There also appeared to have been a genuine improvement both in family relationships and in the children's presentation and behaviour at school following the parents' attendance at the Strengthening Families Programme, suggesting that changes within the family had been made by addressing the concerns around physical chastisement. It is worth noting that even now, several months after the murder, the children have still not made any disclosures of domestic violence.

10.13. Whether each agency has systematic processes in place to ensure compliance with statutory responsibilities to safeguard children in the context of domestic violence including appropriately targeted training.

This was evident in both Children's Social Care and the Early Intervention Service.

10.14. Whether practitioners in all agencies were aware of the needs of the children involved, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child's welfare.

The initial referral to Social Care from the children's school was made appropriately following Luan's disclosure which identified potential concerns about physical abuse. As detailed throughout the report, there was then a joint response from Children's Social Care and the police Child Abuse Investigation Team and subsequent assessment undertaken and plan in place to support the family and ensure that the children's needs were met.

The role of the Social Worker in Social Care is primarily one of safeguarding children. Central is this is the capacity to asses risk and need, which requires a sound understanding of indicators of abuse and neglect, and to be able to respond to these appropriately. The

Social Worker involved with the family is experienced in undertaking Child Protection Investigations as well as Child in Need Assessments, and has received the correct training and qualifications to be able to do so. The Social Worker's line manager had oversight of her involvement with the case and in key decision making.

The 'Strengthening Families' (parenting programme) Facilitators and all Early Intervention Service staff involved with the family were aware of the needs of the children and the presenting issues at the point of referral were addressed in the parenting course.

As outlined earlier, School Nursing was not made aware of the children's needs nd were thus not in a position to increase their vigilance.

11. Was Miriana's death predictable and / or preventable?

There were no agencies that were aware of any domestic violence prior to the murder. To most people, Miriana and Erag presented themselves to the world as a happily married couple and even the few who knew differently, only knew that the relationship was unhappy but not of any abuse. As such, it is difficult to see how events could have been predicted and subsequently prevented.

12. Key findings and lessons learned

1. There were five physical injuries requiring medical attention to the two boys over a four year period. Even with the benefit of hindsight it is difficult to see this as a missed opportunity.
2. Erag minimised his physical chastisement of the children, at times giving contradictory information about the frequency.
3. The Albanian community in London is relatively new and knowledge of UK state structures is generally low. If Miriana had been experiencing domestic violence, it isn't clear that she would know where to go.
4. Miriana and Erag successfully presented themselves throughout the parenting programme as a united couple without any apparent problems. This was at the same time that both parties were telling others that their marriage was unhappy and involved nightly arguments. Information given to others, however, did not cause them to think that the relationship was abusive.
5. There was some limited evidence of known risk factors, in particular jealousy, stalking and coercive control. Whilst Miriana did speak of this, she did not 'name' these behaviours as domestic abuse. Given the prevalence rates of domestic violence against Albanian women, it is possible that Miriana concluded her own circumstances were not severe enough to be considered domestic violence.
6. There is an on-going need for awareness rising within the Albanian community.
7. While there are things that could have been done more quickly such as the referral to the Parenting Programme the Review has not identified any significant opportunities to intervene differently with the family that would have led to a different outcome.
8. The Social Care recordings do not capture all of the Social Worker's contact with the family nor provide the same quality of description and analysis that the Social Worker was able to articulate in discussions about the case. While the case records provide an adequate account of the identified needs and impact of intervention,

they do capture the quality or extent of work that was undertaken with the family. Whilst expectations around case recording must be balanced against the demands and pressures of a busy frontline child protection team, in this case the overall picture of the quality of work undertaken with the family would have been just good enough with some gaps if this report was based solely on case records. This is a discredit to the quality of work and the relationships that the Social Worker formed with the family members, particularly the children.

13. Recommendations

LB Hounslow Community Safety Team

- Review its annual awareness campaign to include targeting employers, the housing newsletter and specialist food shops.
- Carry out a focus group with Albanian women in Hounslow on domestic violence
- Explore the potential for hosting workshops designed to 'help a friend' experiencing domestic violence. The experience of the Empower Project clearly shows that this strategy leads to over 80% of participants discussing the issue within their social networks, helping to raise awareness. Workshop content should recognise the centrality of motherhood to Albanian women and include information on how to protect children.
- Work with Healthwatch to engage the Albania community

Early Intervention Service

- Ensure that staff are routinely involved in all Child in Need meetings involving families they are working with.

Care UK

- Undertake an assessment of record keeping with a view to ensuring that records are complete and accessible.

Children's Social Care

- Children's Social Care to undertake a series of workshops with Social Workers and managers to seek to address and improve standards in case recording, with a focus on better capturing of observations of families, analysis in assessment and in ensuring that key management decisions are recorded in a clear and timely way while ensuring that the expectations of case recording are realistic and do not detract from the time that Social Workers spend undertaking direct work with families.
- Establish lines of enquiry for ensuring that information from and to School Nursing is included with child protection enquiries.
- Attach a full and un-redacted copy of the Overview Report to the children's records

LNWHT:

School Nurses:

- Review the domestic violence questions in the health questionnaire sent out by school nurses to all families School nurses should audit the numbers of returned responses to ensure pathways are being followed.
- School nursing service to develop a process for following up on health questionnaires not received.

Intensive Care Unit:

- Visitors to the ICU need to be monitored. ICU should introduce a visitor's book.
- Clearly documented records of communication stating who and what relationship the visitor has to the patient and conversations held.
- ICU should undertake documentation/record keeping audit.
- Evidence of ICU visitors and contact should be audited after 6 months.

Ealing Alcohol Services:

- Review of services available out of hours to ensure patients attending outside of these times are not missed due to lack of available staff.

NHS England

- Review the domestic violence questions in the health questionnaire sent out by school nurses to all families across London
- In partnership with Ealing CCG, explore the potential for implementing IRIS and work towards the full implementation of NICE quality standards on domestic violence.

Ealing & Hounslow LSCBs:

- To formally raise at a pan-London level the issue of expectations of the school nursing service in the light of continuing budgetary cuts

Appendix A:

TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Specific areas of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the following family members between 2013 and August 2015[5] all resident at address 1:

a) Miriana
b) Erag
c) Luan
d) Bari

2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Miriana:

(a) Communication between services

(b) Information sharing between services with regard to the safeguarding of children

3. Whether the work undertaken by services in this case was consistent with each organisations':

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

[5] Please note that this time frame ONLY applies to those agencies who provided a chronology at the first meeting. Those agencies who have not yet checked their records should do an initial check back to 2002 and then check with the Chair.

4. The response of the relevant agencies to any referrals relating to Miriana, her husband or their children, concerning domestic violence or other significant harm from 2002 onwards until the point of the death. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Miriana and Erag.

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies ' ability to respond effectively.

10. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

TERMS OF REFERENCE FOR THE CHILD ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

11. In relation to this Review the children are not identified as victims as specified in paragraph 3.3. 3.4 and 3.6 of the DHR Guidance. The primary role of this element of the Review in relation to the children affected is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children.

12. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in Hounslow and also any other agencies and local authorities. It should also highlight any good practice that can be built upon.

13. Specifically the areas of this Review relevant to the **children** involved are as follows:

(a) Whether the agencies had in place policies and procedures for safeguarding and promoting the welfare of children in relation to domestic violence and whether there were any failings in the policies and procedures themselves, in the implementation of policies and procedures, in management oversight or in compliance with policy and procedures.

(b) How well the needs of, and potential risks to, the children involved were identified by all agencies and how well were the child and the parents engaged in this process. In particular the Review will explore whether the impact of domestic violence on the children was recognised and appropriate action taken to respond to their needs in the light of what was known by any agencies about domestic violence that was occurring in the household.

(c) Whether each agency has systematic processes in place to ensure compliance with statutory responsibilities to safeguard children in the context of domestic violence including appropriately targeted training.

(d) Whether practitioners in all agencies were aware of the needs of the children involved, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child's welfare.

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. Any delays to this deadline will be communicated to the Home Office.

The Review will aim to finish by the end of May 2016. The next two meetings of the Panel will be:

29th January at 2pm

12th February at 2pm

A meeting has also been set for March 16th at 10am which may or may not be needed.

At least one further meeting will be required in to discuss the final report.

All meetings will be held at Hounslow Civic Centre.

Media strategy

Any media enquiries prior to the conclusion of the trial must be referred to the Metropolitan Police. Post-trial, enquiries should be directed to the Chair.

Chairing & Governance

An independent chair has been appointed to lead on all aspects of the review and will report to the chair of the Hounslow Community Safety Partnership.

A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence services.

The Hounslow Community Safety Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

Agency roles and responsibilities

- Delegate a senior officer to lead on the review on behalf of their organisation
- Senior officers will attend all Panel meetings
- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report

Information Sharing & Confidentiality

The principles outlined in the Hounslow Community Safety Partnership's Information Sharing Protocol will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Review. Revised – applicable to all notifications made and including 1 August 2013.

Appendix B: Cross-Government definition of domestic violence

The cross-government definition of domestic violence and abuse is:

any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

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.

Coercive behaviour

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.

Appendix C: Action Plan