EXECUTIVE SUMMARY REPORT INTO THE MURDER OF MIRIANA, AUGUST 2015

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

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.

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. There are a range of domestic violence services in Hounslow which, among others, includes the Hounslow Domestic & Sexual Outreach Service, Victim Support Independent Domestic Violence Adviser Service, a monthly Multi-Agency Risk Assessment Conference (MARAC), a One Stop Shop, a Refuge and a Sanctuary Scheme as well as 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.

2. Overview

Persons involved in this DHR[1]

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
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 years and six months. 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 after one of their sons disclosed at school that his father sometimes hit him. The investigation uncovered that their two sons had suffered five injuries requiring medical attention in the previous four years but each had a reasonable explanation and Mariana and Erag were co-operative with the investigation process. The investigation resulted in both Mariana and Erag attending a parenting programme where they presented a united front and participated well. There was no known history of domestic violence although friends did know that the marriage was unhappy and described some elements of controlling behaviour. This had become significantly worse subsequent to the child protection investigation and Mariana beginning a platonic friendship with another man. Erag told his GP that was suffering from insomnia and depression.

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.

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

[1] All names in the table are pseudonyms

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 in the main report. In summary, these were as follows:

- Did each agency follow its policies, procedures and professional standards with respect to record keeping, information sharing, risk assessment and management?
- What was the response of each agency to any referrals relating to Miriana, her husband or their children, concerning domestic violence or other significant harm from 2002[2] onwards? Were these responses timely and effective?
- Were staff able to access appropriate training? Were there any organisational issues which impacted on services delivered?
- Were services provided sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members?

[2] Later revised to 2013

- 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 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 Individual Management Review (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

Recommendations to address lessons learned are listed at the end of this report and an action plan to implement those recommendations are catalogued in Appendix C of the main report.

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.

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

8.4. The Panel were extremely grateful to Mirkena Shqarri-Palluqi, a former case worker on the Empower Project. Along with the evaluation of this project, her presentation to the Panel provided a valuable insight into Albanian women and domestic violence. In summary:

The Albanian community in the UK is relatively new and even now, remains relatively small. Few Albanian women migrate independently; 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.

Changes in the political regime in Albania have shaped the status of women; after the collapse of communism 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.

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.

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. Suspicions of infidelity on the part of women are widely seen as justification for homicide.

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.

[3] This was a partnership between Solace and Shpresa

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. Analysis

The Individual Management Reviews were 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. 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.

11. 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.
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.

12. 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 & Harrow 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