Oxford Safer Communities Partnership

Domestic Homicide Review

Updated Overview Report into the death of Elira (June 2019)

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1. INTRODUCTION

This domestic homicide review was commissioned by Oxford Safer Communities Partnership following the death of Elira. The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides 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 he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himse*lf

In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This report examined the contact and involvement that agencies had with Elira, her husband and their two children between October 2018 and the time of Elira's death in June 2019. In addition to the agency involvement, this report also examined any relevant past history of abuse and incorporated the views and thoughts raised by Elira's family and friends.

The panel wishes to express their condolences to Elira's family and friends following her death. The panel would also like to thank all those who have contributed to this review.

1.1. Timescales

Oxford Safer Communities Partnership was notified of Elira's death on 17 June 2019. The Partnership reviewed the circumstances against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) and recommended to the Chair of the Community Safety Partnership that a domestic homicide review should be undertaken. The Chair ratified the decision to commission a domestic homicide review on 24 June 2019 and the Home Office was notified on 24 June 2019. In September 2019, a letter (in English and Italian) was sent to Elira's family in Italy explaining that a domestic homicide review would be undertaken. The commencement of the domestic homicide review was delayed because of the police investigation and the subsequent trial in December 2019. The target date for completion of the overview report was April 2020 - however, the review was paused during the Covid19 lockdown.

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Panel.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

Elira – deceased aged 35 years
Perpetrator – husband aged 45 years
Elder child
Younger child

} Age at the time of Elira's death

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2. THE REVIEW PROCESS AND TERMS OF REFERENCE

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004).

2.1. Time period

The panel decided that the review should focus on the contact that agencies had with Elira, her husband and their children between October 2018 and the time of Elira's death in June 2019. This period encompasses the time that they arrived in the United Kingdom up to the time of Elira's death. It should therefore capture any information about the couple's relationship and any reported history of abuse and violence within their relationship. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included within the agency's individual management review or information report.

2.2. Contributors to the review

Elira's family was approached via their Thames Valley Police family liaison officer and the children's social worker. The family were in Italy by this time and felt they had nothing further to add to the review. Therefore, they were not offered specialist advocacy from the UK but rather specialist support for the family and children was identified in Italy. Elira's friend was asked if she would like to contribute to the review but she felt too distressed to engage. The perpetrator (who was not engaging with anyone) was not approached to contribute. Therefore, the majority of the information about Elira and her children came from the police investigation into her death.

2.3. Agencies and other contributors to the review

Individual management reviews and chronologies were requested from:

- General Practitioner
- School

Information reports and chronologies were requested from:

- Children's Social Care
- Thames Valley Police

All the authors of the individual management reviews and information reports were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved. All agencies included any relevant information about Elira, her husband and their children.

2.4. Key lines of enquiry

The review addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

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- What knowledge or information did your agency have that indicated Elira might be at risk of abuse, harm or domestic violence and how did your agency respond to this information? Was information shared and with which agencies?
- Did your agency directly ask either Elira or her husband about domestic abuse? If so, what questions were asked and how did your agency respond to the information they provided?
- What knowledge or information did your agency have that indicated Elira's husband might be violent or abusive and how did your agency respond to this information? Was information shared? If so, with which agencies or professionals?
- Was there anything about the perpetrator's or Elira's presentation to suggest she was a victim of coercive control? Was there anything about the children's presentation to suggest that they were victims of coercive control?
- Was there anything about the children's presentation that indicated that they were witnessing domestic abuse or living in a household with domestic abuse? If so, how did your agency support the family?
- What did professionals understand about the cultural issues in the family (e.g. language, religion, ethnic origin) and how did these issues influence professional practice? Did professionals question Elira's or the perpetrator's understanding of English?

SPECIFIC ISSUES FOR INDIVIDUAL AGENCIES

All agencies were asked to address the key lines of enquiry. In addition, agencies were asked to address some specific issues.

- General Practitioners

Were there opportunities to speak with Elira on her own? If so, was she asked any routine questions about domestic abuse? Did she have a good understanding of English and was she able to articulate her thoughts? Were any of her attendances thought to be consistent with being a victim of domestic abuse?

- School

The individual management review should provide a picture of Elira's presentation when she collected her children from school? Did she have a good understanding of English? Did she chat to the other mothers? How did the perpetrator present – did he socialise with other parents or speak with teachers etc.? Did the children have 'sleep overs' at other houses or have friends back to their house (if known)? Did the children join in with after school clubs etc? Was there anything to suggest that the children might be distressed or worried about things at home?

- Children's Social Care

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The information report should include any background information that may inform this domestic homicide review. Did the children provide any information about family life or their life in Italy before arriving in the United Kingdom?

- Thames Valley Police

The information report should provide as much background as possible about the family including whether Elira had a bank account and access to her own money. It should set out any information about the deterioration in the perpetrator's mental health when the family lived in Italy – and include his criminal history whilst living in either Albania or Italy (if known).

2.5. Review panel

The review panel met four times. All the members were independent of the case i.e. they were not involved in the case and had no direct line management responsibility for any of the professionals involved in the case. The review panel comprised:

- Eleanor Stobart, Independent Chair and Author
- Agya Poudyal, VAWG Strategic Officer, Thames Valley BAMER Project
- Alison Chapman, Designated Nurse for Safeguarding, Oxfordshire CCG
- Becci Seaborne, Service Manager A2 Dominion (Domestic Abuse Service)
- Caroline Green, Assistant Chief Executive, Oxford City Council
- Clare Knibbs, Detective Chief Inspector, Thames Valley Police
- Delia Mann, Head of Service Family Solutions, Oxfordshire City Council
- Hannah Forder-Ball, Head Teacher
- Liz Jones, Domestic Homicide Review Lead, Oxford City Council
- Maria Godfrey, Head of Service Front Door, Oxfordshire City Council

2.6. Author of the overview report

The chair and author of this review has been an independent consultant for 20 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse. She has chaired and authored over 20 serious case reviews/domestic homicide reviews. She has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011). She is independent of, and has no connection with, any agency in the Oxford area; she has never been employed by any agency in the Oxford area. She has not completed any previous domestic homicide in Oxford.

2.7. Parallel reviews

There were no parallel reviews undertaken.

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2.8. Equality and diversity

The family are of Albanian origin. They had lived in Italy for a number of years. The children were described as being fluent in Albanian and Italian as well as having a good understanding of English.

All aspects of equality and diversity were considered throughout this review process including age, disability, race, gender and religion. Advice was sought from an organisation called 'Shpresa' which promotes the participation and contribution of the Albanian speaking population in the UK. The Chair of the review and the Domestic Homicide Review Lead for Oxford City Council visited 'Shpresa' to gain a better understanding of the cultural issues that may have had an impact on the family. The information 'Shpresa' provided was invaluable and much of it is included within the body of the report. To ensure the review process considered issues around domestic abuse the panel included representatives specialising in domestic abuse. Their thoughts and views are also reflected throughout the report. Issues of equality and diversity together with all the relevant 'protected characteristics' are discussed in the body of this report.

2.9. Dissemination

In addition to the organisations contributing to this review (listed in paragraph 2.3), the following will receive copies of this report:

- Oxford Safer Communities Partnership
- Thames Valley Police and Crime Commissioner
- Oxfordshire Safeguarding Children Board
- Oxfordshire Safeguarding Adult Board
- Oxfordshire Domestic Abuse Strategic Board
- Coroner's Office

3. THE FACTS

On a day in mid-June 2019 in the early hours of the morning Thames Valley Police was informed that South Central Ambulance Service was on route to an incident where it was reported that a man had been stabbed by his wife. Police officers arrived before the ambulance service and discovered the perpetrator with substantial injuries and Elira with unsurvivable knife wounds. It appeared that during the night the perpetrator had called a female relative asking her to come to collect their children. When she arrived at the house, she called the ambulance. Police found four notes (three in Italian and one in Albanian) that had been left by the children's beds. The note in Albanian translated as "*Betrayal is only settled by death*". Another in Italian implied that Elira had had relationships with other men (there was no evidence to suggest this was true).

The perpetrator was taken to the John Radcliffe Hospital where he remained for 3 weeks. He was later charged with Elira's murder and he was remanded into custody. His trial took

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place in December 2019. He was found guilty of murder and sentenced to a minimum term of 19 years' imprisonment.

4. BACKGROUND AND CHRONOLOGY OF SIGNIFICANT EVENTS

Elira and the perpetrator grew up in Albania. They had known each other since they were young and their families were well acquainted. Both were non-practicing Muslims. Their marriage was described as an "*arranged marriage*". Arranged marriages are common in northern Albania and it was reported that they "*both wholly agreed to it*". They had been married for about 12 years and had two children. Elira and the perpetrator moved to Italy where they lived for some years and owned a property. During their time in Italy, their younger child became very ill and apparently this experience was particularly difficult for the perpetrator. There was some indication that he had struggled to deal with the situation. His mental health suffered and he became depressed. It is unknown whether this was a formal diagnosis or whether he received treatment for his depression.

The perpetrator had relatives in Oxford and they thought the education system in the United Kingdom would provide better opportunities for their children. They were concerned about the impact of 'Brexit', so in 2018 they decided to move to the UK. The perpetrator came alone to the UK on 21 August 2018 to find housing and employment. During this time, he stayed with his cousin.

The perpetrator found a two bedroomed family home to rent. He secured employment as a cleaner at a local factory. He worked permanent night shifts from Monday to Friday (9pm until 6am). Elira and the children joined him in the UK on 3 October 2018. The children were enrolled at a school in Oxford. Elira also secured employment at the same local factory. It appeared that Elira had two roles. One as a cleaner and the other on "*checking parts*". Elira and the perpetrator worked opposite shifts.

In addition to his cousin, the perpetrator also had other relatives living nearby. These included two other cousins and their partners. Elira’s parents and her sister lived in Albania and she had two brothers living in Italy. The wider family described the perpetrator and Elira as being very loving towards each other. They said there were no indications of any trouble or issues between them. Indeed, Elira’s death and the circumstances in which she lost her life came as a great shock to them all. The perpetrator's relatives in Oxford regularly spent time together. In fact, five of them had been at the perpetrator's and Elira's house for a family gathering the afternoon before Elira's death.

There were no reports from the family of any history of domestic abuse. Although as part of the investigation, their elder child told police that their parents sometimes argued. The elder child had heard them arguing because the perpetrator wanted to look at Elira’s phone which resulted in him smashing it. During the trial, one of Elira's work colleagues also described this incident. She told the police that Elira had gone to work with a black eye. When the work colleague asked about it, Elira said it was the perpetrator who caused it because he had found messages on her phone. Elira said she was not allowed to have friends. After smashing the phone, the perpetrator was apologetic, he asked for

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"*forgiveness*", and the phone was replaced. It appeared that he had accused Elira of having affairs and called her a "*whore*" (there was no evidence on her phone that she had any contact with other men). There also appeared to be some issues around control, as Elira was not allowed to use social media.

According to their elder child, another area of tension concerned their work. The perpetrator wanted to do the same job as Elira (checking parts) but he failed a test because his English was not as competent as his wife's. This resulted in him feeling he had let the family down.

Both the perpetrator and Elira drove and they had use of a shared car whilst in the UK. Elira had her own bank account which was in credit with over £1000 at the time of her death. Elira, the perpetrator and their children were bilingual, they spoke fluent Albanian and Italian. Their children also spoke very good English. Checks on the PNC (police national computer) and with Interpol indicated that neither Elira nor the perpetrator had any previous convictions. The children now live with their maternal uncle and his family in Italy.

5. AGENCY INVOLVMENT AND ANALYSIS

5.1. Thames Valley Police

Thames Valley Police had no contact with the family until a call was received from South Central Ambulance Service just after 5am on a day in mid-June 2019. The information provided to the police about the incident was "*very vague*" i.e. the circumstances of the incident were unclear and the details of the caller and the parties involved were unknown. Despite this, there was sufficient information to warrant the call being graded as requiring immediate response. Incident and Crime Response police officers[1] arrived within six minutes of the call being received.

On arrival, they were met by the perpetrator's cousin who had called South Central Ambulance Service. She directed the officers into the house. The perpetrator was found in the bedroom with significant injuries but he was conscious. Elira was found under bedding with unsurvivable injuries. The officers provided first aid to the perpetrator but quickly realised they needed a chest seal.[2] Currently, chest seals do not form part of the first aid kit available to Incident and Crime Response police officers. Nevertheless, an armed response vehicle had been requested to attend the incident. Armed response officers have enhanced first aid training and access to other lifesaving equipment such as chest seals and defibrillators. When the armed response officers arrived, preparations were made to use the chest seal, but South Central Ambulance Service arrived and assumed command of the perpetrator's medical treatment.

[1] These are uniformed police constables who police the area on which they are based. They respond to all incidents (as directed by the sergeant or the force control rooms) including those requiring an emergency response.

[2] A chest seal is used to cover penetrating chest wounds. It allows air to escape from the pleural cavity without being drawn back in – thus preventing a tension pneumothorax (collapsed lung)

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A police officer's primary duty is to protect life. Police officers however are not trained to certify death. Thus, normally attempts should always be made to save life no matter how futile it may seem. This incident was one of the very rare incidents where it was obvious to anyone (whether medically trained or not) that sadly nothing could have been done to save Elira's life. The officer's decision to focus their attention on the perpetrator was correct in the circumstances. This is supported by the Thames Valley Police 'Unusual, Unexplained or Suspicious Death' Policy (May 2019) which states '*it is a fundamental responsibility of the police to preserve life; and first attending officers should not assume that a person is dead unless the circumstances are plainly obvious to the non-medically qualified. If there is any doubt whatsoever, first aid/CPR should commence and an ambulance should be summoned immediately'*. South Central Ambulance Service arrived three minutes after the response officers and agreed with the police officers' actions and decisions. Ambulance staff confirmed that Elira was dead.

On this occasion the chest seal and support from South Central Ambulance Service arrived soon. Nevertheless, this may not always be the case, particularly in rural areas. Since April 2019, frontline officers who respond to emergencies have been receiving enhanced first aid training. This has helped to equip them to deal with trauma and haemorrhage injuries. In addition, since January 2020 'trauma packs' are kept within emergency response vehicles. These trauma packs contain (amongst other things) chest seals.

South Central Ambulance Service dealt with the initial call and was the only agency communicating with the caller. There are occasions when calls do not go through to the agency that is most suitable to deal with the incident. For example, sometimes the caller may need first aid guidance, on other occasions there may be a need for accurate and in-depth information to ensure the safety of officers or the wider public – sometimes there is an urgent need for both. Previous reviews identified that a conference call or 'talk through' facility between Thames Valley Police and South Central Ambulance Service would have been very useful.

Such a facility would enable both agencies to obtain the different information they require and provide their separate advice and guidance simultaneously. This would ensure the most effective and timely response to the incident. In 2017, three-way discussions took place between the Thames Valley Police Service Improvement & Investigation Review Team, Contact Management and South Central Ambulance Service. The aim was to scope the possibility of introducing a 'talk through' facility. Ultimately the discussions did not progress even though it was thought that the appropriate technology existed. It is not known whether the new Control Management Platform will contain the appropriate features to facilitate a 'talk through' system.

5.2. General Practitioners

Elira registered herself and her two children at a GP Practice on 5 October 2018. This was two days after entering the UK. The perpetrator was not registered at this GP Practice nor with any other GP Practice whilst he was in the United Kingdom.

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There were no recorded GP consultations with Elira's elder child and no evidence that the elder child attended the GP Practice. Nevertheless, there was a letter from the emergency department in Oxford dated 10 June 2019. The letter reported that the child was brought in by the perpetrator having sustained an injury during a physical education class. An X-ray showed a fracture of the child's fifth metatarsal. This incident was confirmed to the review panel by the school.

The younger child attended an appointment with their mother and sibling on 17 December 2018. They had a conversation via a phone interpreter. The notes recorded that the younger child had previously had Kawasaki disease which had resulted in a heart problem. The younger child's last follow-up appointment had been in Italy in June 2018 and Elira hoped the child's care could continue in the United Kingdom. Elira was asked to acquire a summary in English of her younger child's health problems and the child's ongoing needs. The child could then be referred on appropriately, if needed.

NHS England[3] guidance states "*Where patients register with a practice and are in possession of documents in languages other than English which relate to their health, these should be translated into English as soon as possible where there is an identified clinical need. The documents should be included in the patient record in both languages where this is deemed necessary*". In this case, the GP Practice stated that Elira was asked (in the first instance) to acquire the summary because, for reasons of consent and confidentiality it is often quicker. There was however no follow-up on this action over the next six months.

Elira's notes recorded that at the end of her younger child's appointment on 17 December 2018, Elira asked for a review of her own medication. She was advised to book an appointment. She was seen in January 2019 and it was documented that she was accompanied by the perpetrator. 'Google Translate' was used during the appointment (this is not considered best practice).[4] The notes recorded that she was a little bit tired and her hair was thinning. She said she was working as a cleaner for a few hours a day. She was given an ongoing prescription and had a blood test.

The perpetrator attended a follow-up appointment instead of Elira. It was recorded that she had had to reschedule her appointment because of her work commitments. It was explained to him that the GP Practice would not be able to give any information to him about Elira's health. An appointment was rearranged for her to see a GP the following morning. At that appointment, she was advised to continue the same dose of medication and to book another appointment for a blood test in six to eight weeks' time. Records showed that she had another test in June and the results were normal.

[3] Guidance for Commissioners: Interpreting and Translation Services in Primary Care, NHS England September 2018

[4] Principle 7.7 Guidance for Commissioners: Interpreting and Translation Services in Primary Care, NHS England September 2018 states "*Automated on-line translating systems or services such as "Google-translate" should be avoided as there is no assurance of the quality of the translations*".

Elira was seen for an asthma review on 30 April 2019. The consultation was done using Language Line. Her asthma medication was changed and she was seen again by a GP for a review in early June 2019. Elira told the GP that her asthma symptoms had improved.

Neither Elira's records nor the consultation with the GPs highlighted any concerns, difficulties or distress. It appeared that Elira saw different clinicians on her visits and it was not always documented who accompanied her. Nevertheless, when interviewed for this review, all the GPs recollected that she had been accompanied by her husband.

Domestic abuse training for GPs is based on their individual portfolios and varies depending on their competence, expertise and other CPD (continuous professional development) requirements. Within the GP Practice, domestic abuse is part of the discussion at the safeguarding partnership meetings. During this meeting the safeguarding lead facilitates case discussions and action planning for vulnerable patients. There was also a training event on domestic abuse at the GP Practice in 2016. This was a 3-hour session, and an update took place in January 2020. There is a rolling programme of evening events that cover the core topics in rotation, and in addition updates are provided from domestic homicide reviews and other reviews. The domestic abuse training for GPs and Practice staff covers issues around patients being escorted to appointments and how this can be a sign of domestic abuse. Staff are encouraged to document who attends with the patient. The training also covers how to make opportunities to see patients on their own, so they can openly discuss or disclose potential issues around domestic abuse.

It is difficult to know how many Albanian patients are registered at the GP Practice. Country of origin is not a mandatory field when registering at a GP Practice and documenting someone's ethnicity would not elicit this information. Nevertheless, understanding a person's cultural background may be an important part of understanding their health needs.

5.3. Schools

Both the children attended school in Oxford. They had only been at the school a few months when their mother died. The younger child was described as having little to no English but he worked hard at language. The younger child was described as a polite child who was well liked by peers and wanted to do well. The elder child was described as happy and making good progress. The elder child had a good friendship group. There was nothing about the children's presentation that raised any concerns. There were no reports about poor behaviour.

There are a number of children at the school whose country of origin is Albania or Italy. Currently, the school does not have a system in place that can distinguish children by the languages they speak. Nevertheless, the school has a number of staff who are multilingual and therefore staff are able to communicate with most parents in their native language, especially parents speaking European languages. The school's only unusual observation about the family was that both parents came to the school to drop the children off and collect them. Elira was therefore never seen on her own, as she was always in the company of her husband. They did not socialise with other parents on the playground. They did however give the impression of a happy family.

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The school's individual management review asked for additional support and training in order for them to identify the signs of coercive behaviour and manage any suspicions. The Oxfordshire Safeguarding Children Board offers training on domestic abuse which includes information about coercive control. Currently (due to Covid19) the training is available online. The training contains information on:

- Definitions of domestic abuse, controlling and coercive behaviour
- Understanding the impact of domestic abuse
- The Oxfordshire domestic abuse pathway for young people
- The DASH (domestic abuse, stalking and honour-based violence) risk assessment
- The Oxfordshire Domestic Abuse Services helpline

On completion of the eLearning course, practitioners are also able to attend a live, trainer-led webinar which gives them the opportunity to ask Oxfordshire Safeguarding Children Board trainers any questions about the content of the completed eLearning course.

6. EMERGING THEMES

There was very little information available about Elira and her life in the UK. What we do know is that her husband appeared to escort her to her GP appointments and they collected the children from school together. They appeared to only socialise with his relatives. They worked opposite shifts. Elira therefore cared for the children overnight and worked during the day. During the police investigation into her murder, one of her children described an incident when the perpetrator broke Elira's phone (he apologised and replaced it). She was also not allowed to use social media. Clearly, these issues indicate that the perpetrator was controlling. Nevertheless, there was so little information about Elira's world that to draw further conclusions would be speculation. Therefore, the panel considered whether Elira may have faced some of the additional difficulties and barriers outlined below.

6.1. Migration and vulnerability

It is well documented that migrating families face particular difficulties. These can include isolation from extended family, a sense of not belonging or feeling threatened, misunderstood and confused. The expectations associated with migration, such as the quality of life, levels of income and ability to help relatives overseas financially may not be fulfilled. Other stresses include continuing uncertainty around immigration status, being unable to work, living in inadequate housing and not receiving the recognition of status, value or worth that they held in their home country. Many major changes, particularly those resulting from migration, can cause significant stress to individuals especially those trying to manage conflicting identities. These difficulties can often lead to mental health problems. 'Shpresa' explained that there is no language in Albania to describe mental health problems, thus preventing both men and women seeking help.

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CULTURAL DIFFERENCES

Albania is small country which emerged from communist isolation at the end of the 1980s. Although Albania is a predominantly Muslim country, as a result of the rigid enforcement of atheism during the communist regime, today most Albanians are adherents of religious groups in name only. Many people practice a largely secular lifestyle.[5] Research describes Albania as having "*a macho male culture with deep rooted patriarchal values*". Therefore, often women are not regarded as the equal of men. [6] It is a poor country with high unemployment and one-third of the population lives in poverty.[7] These circumstances have contributed to a culture where domestic abuse is widespread and it is sometimes regarded as acceptable. Attitudes to women are beginning to change and the government is seeking to address domestic abuse both through legislation as well as increased police awareness of the issue.[8] 'Shpresa' described how 'shame' and 'honour' can play a significant part in Albanian women's lives. Honour and shame rest with the women and it would bring shame on the family to discuss domestic abuse outside the family. Although it appears that divorce is becoming more common in Albania, this is generally amongst younger people. Despite this, there remains "*societal prejudice*" against divorce in northern Albania.[9] The stigma associated with divorce can lead children to be bullied at school or within the neighbourhood. Women will often remain in a marriage so they do not bring shame on themselves or their family. Many women do not believe they have the right to a divorce if there has been no violence or abuse. It is for these reasons that some victims of domestic abuse who have migrated to the UK, may not be confident to report domestic abuse, particularly to agencies such as children's social care and the police. In one article a woman described how reporting domestic abuse to the Albanian police only resulted in her being sexually harassed by the policeman to whom she reported her experience.[10]

These barriers mean it is essential that professionals try to make opportunities to see women on their own. In this case Elira was escorted to the GP Practice and the couple always went to the school together.

For many migrants there may be many cultural differences ranging from social customs to more significant issues such as attitudes towards gender, religious diversity, ethnicity and sexuality. These can all be vastly different in a new country.

[5] See for example https://www.britannica.com/place/Albania/Climate - accessed online 10 December 2019
[6] Country Policy and Information Note. Albania: Domestic abuse and violence against women (version 3), Home Office December 2018 – accessed online 18 February 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771648/Albania_-_D.A._-_CPIN_-_v3.0__December_2018_.pdf
[7] See for example https://www.britannica.com/place/Albania/Climate - accessed online 18 February 2020
[8] Country Policy and Information Note. Albania: Domestic abuse and violence against women (version 3), Home Office December 2018 – accessed online 18 February 2020
[9] Country Policy and Information Note. Albania: Domestic abuse and violence against women (version 3), Home Office December 2018 – accessed online 18 February 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771648/Albania_-_D.A._-_CPIN_-_v3.0__December_2018_.pdf
[10] The reality of violence against women in Albania http://www.womensmediacenter.com/fbomb/the-reality-of-violence-against-women-in-albania - accessed online 18 February 2020

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In Albania the role of men in the family is one of authority and bread winner. Women are expected to do the housework and raise the children. Women are protective of their children and see the family as their main priority and will endure unhealthy relationships to keep the family together. When families move to the UK women often adapt well. They pick up the English language quicker, primarily because they are the main carers for children and will interact more with other people e.g. schools and health professionals. This in turn may lead them to get better jobs and earn higher salaries. This can lead to a power shift within the family, as may have happened for Elira and the perpetrator.

ISOLATION

Missing the support of family and friends is also a big factor for many migrants. Those who come from societies where traditional support structures within communities are strong can find that they feel lost, alienated and disorientated when moving to a Western country where individualism is often prized over family. Although the perpetrator had family in Oxford, none of Elira's family were living in the UK. This may have led to her being further isolated, as she may have felt unable to approach the perpetrator's family for help or support.

LANGUAGE BARRIERS AND ACCESS TO SERVICES

Language is certainly a barrier for migrants. For many victims who find themselves in these circumstances, there are limited safe places to go to if they want to leave an abusive relationship. This is made all the more difficult if their first language is not English or they do not speak English. Some languages do not have the words for domestic abuse and victims may find themselves unable to articulate what is happening to them. Abusers often use threats of having children removed, uncertain immigration status, financial dependence and isolation to silence the victim and prevent them seeking help.

In this case, the family was not previously known to children's social care. Nevertheless, children's social care worked intensively with the children and their wider family following Elira's death. This provided some opportunities for children's social care to reflect on aspects of their work. For example, the need to be culturally sensitive whilst always ensuring that the wishes and feelings of the children were paramount in planning for their future in the absence of their parents. This was made less problematic because of the amazing strength shown by both the maternal and paternal extended family. It was to their credit that both sides of the family worked together to ensure that the children’s best interests were always the highest priority. It was clear from the discussion with 'Shpresa' that in Albanian culture life is very family-orientated with children and their education being central to the family.

6.2. Arranged and forced marriage

Elira and the perpetrator's marriage was described by family members as an arranged marriage. According to 'Shpresa', in Albania it is accepted that a girl will marry whoever her father decides on. Some girls do try to escape by running away with men who they believe are in a relationship with them, but all too often they are exploiters or traffickers who prey on vulnerable girls. This helps reinforce the notion that a father is right to choose a husband

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for his daughter. Fathers prefer their daughters to marry someone who can provide for them and therefore the age of the prospective husband is not an issue. This means that a woman may have to marry a much older man. Research[11] shows that there is little consideration within Albanian law concerning forced marriage and this was confirmed by 'Shpresa'. In the UK guidance states:

> There is a clear distinction between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage, but the choice of whether or not to accept the arrangement still remains with the prospective spouses. However, in forced marriage, one or both spouses do not consent to the marriage but are coerced into it. Duress can include physical, psychological, financial, sexual and emotional pressure.[12]

In some instances, an agreement may have been made about a marriage when a child is only an infant. This means that some young people "*live their entire childhoods with the expectation that they will marry someone their parents select*".[13] We will never know whether pressure was put on Elira to accept the arrangement but we do know that the families were well acquainted. It is likely that neither Elira nor the perpetrator had any say in whether they were married or not.

7. CONCLUSION

This review highlighted the need for professionals within all agencies to have a good understanding of the cultural dimensions to domestic violence and abuse including coercive control. It is possible that opportunistic questioning may help a woman disclose that they are suffering domestic violence and abuse. Even if she does not disclose anything the first time the issue is raised, it shows that the professional understands the issues and it may give her the confidence to disclose in the future. Clearly, by simply talking about domestic abuse and coercive control, professionals may be able to help some victims recognise and understand what is happening to them. Professionals also need to be equipped to refer victims to specialist services. While domestic violence occurs across all ethnic groups, cultural differences do have an impact on some individuals' ability to access services and receive effective intervention. Service providers therefore need to be aware that women from overseas (and those born in the UK from other backgrounds) may face additional barriers and have specific difficulties that need to be considered. Some women

[11] Country Policy and Information Note. Albania: Domestic abuse and violence against women (version 3), Home Office December 2018 – accessed online 18 February 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771648/Albania_-_D.A._-_CPIN_-_v3.0__December_2018_.pdf

[12] Multi-agency practice guidelines: Handling cases of Forced Marriage HM Government 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf - accessed online 18 February 2020

[13] Multi-agency practice guidelines: Handling cases of Forced Marriage HM Government 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf - accessed online 18 February 2020

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may wish to be referred to culturally specific services, whereas others may not wish to speak to someone from their own community. In these situations, having a choice is key.

8. RECOMMENDATIONS

i. All Thames Valley Police frontline emergency response (ICR) officers to have access to chest seals within vehicle first aid kits.

ii. Thames Valley Police and South Central Ambulance Service should consider the need for, and explore the possibility of, implementing a conference call or talk through facility.

iii. Primary Care leads should review the options for supporting GP Practices to ensure that they are able to meet the requirements of the Equality Act 2010 legislation (in terms of translation and interpretation services) in order to provide safe clinical care to their patients.

iv. Oxford Safer Communities Partnership should ensure the recommendations from the Thames Valley VAWG BAMER[14] Project Report, where applicable, are embedded in the Oxfordshire Domestic Abuse Strategy and Action Plan.

v. Oxford Safer Communities Partnership should consider how best to ensure that the learning from domestic homicide reviews is coordinated and shared as widely as possible. The learning should be linked across the Oxfordshire Safeguarding Children Board, the Oxfordshire Safeguarding Adult Board as well as the Oxfordshire Domestic Abuse Strategic Partnership. This should ensure that all practitioners have an understanding of:

   - Coercive control and the additional barriers facing Black and minoritised victims of domestic abuse
   - The themes that have emerged from local reviews

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[14] Violence against women and girls (VAWG) Black, Asian, Minority Ethnic and Refugee (BAMER) Project Report