



Newham Safety Partnership

Domestic Abuse Related Death Review

Name: Wafiya

Died May 2022

Chair and Author: Derrick Laing

October 2024

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Introduction

1. The Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Wafiya (not her real name), a resident in the Borough of Newham at time of her death in May 2022. The names have been anonymised to protect the family.
2. The Chair and DARDR panel members offer their deepest sympathy to the family and friends of Wafiya. They are grateful to those who have contributed to the review. Wafiya's sister gave a description of their family relationship.

Bahija

From day one, Wafiya and I fought like sisters but loved each other like sisters. Mum was very poorly when we were growing up – she had a brain tumour which was removed but this left her bed bound and paralysed for 14/15 years of our young lives. Our brother was only 2 years old when she was diagnosed. Wafiya brought me and my brother up, effectively. Mum was very poorly and Dad was always working. Wafiya played a great role model. We had a lot of fun when we were young. At 16/17 Wafiya wanted to start working. She was doing well in education. She met her partner. I knew they were very much back and forth, but she decided she wanted to stay with him and became pregnant. We always stayed in contact. She gave birth then came around with her son. We are a huge Indian family, and everyone is well connected. Wafiya was the oldest out of all the family. Her death left us all traumatised and affected a lot of the family.

Wafiya was very bubbly. We were always involved and invited to family events. Her husband picked and chose whether he attended events or not. We would meet with them as a couple, and they came around at Christmas. Wafiya expressed financial concerns to me a few months prior to her death. In the few months after Christmas, she would visit with her husband, and he was not always happy in conversation and there was distance. I asked at the Easter BBQ why Wafiya wasn't in contact as much, but we still checked in with her and always checked in with the children.

My Dad had an amazing relationship with Wafiya. He constantly would call her and check in with her and the children 3 times a day. He misses Wafiya so much. She was the heart and soul of the family, caring and loving. Even though she had started to struggle financially she still made an effort to make gifts for family and ensure everyone was happy. She did this for her kids also. It was her end goal to look after the children. I have the children now. I cannot say a bad word about her.

The circumstances leading to the review.

3. In May 2022 the Metropolitan Police received a call from Mahal to attend his home address in Newham. He told the police operator that he had stabbed his wife. The two children aged eight and nine had witnessed the incident.

4. Police and London Ambulance Service (LAS) attended and found Wafiya with multiple stab wounds. Attempts to save her life took place but she could not be resuscitated at the scene.
5. Mahal was arrested for murder. He was interviewed during which he said, "I am guilty you can charge me." In April 2023 he appeared at the Central Criminal Court where he was found guilty of the murder of his wife Wafiya. He was sentenced to life imprisonment and ordered to serve a minimum of 21 years.

Purpose of a DARDR

6. The key purpose of undertaking a DARDR is to enable lessons to be learned from deaths where there is a potential link to domestic violence and or abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death and more importantly, what needs to change to reduce the risk of such tragedies happening in the future.
7. The Review will examine the history of interactions between the agencies Wafiya and Mahal to identify any relevant background to establish whether support was accessed through the community and whether there were any barriers to accessing the support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

Timescales

8. The Chair of Newham Safety Partnership commissioned the Review on (date). The Chair/Author was appointed to conduct a Review into the circumstances of Wafiya's death in May 2022. The first panel meeting was arranged for 28 June 2022. As the criminal investigation was still ongoing, the panel agreed to suspend the review until after court proceedings were concluded. The Home Office were notified by email.
9. On 20 June 2022 Newham Safeguarding Children Partnership carried out a rapid review to consider the impact on the children who had experienced emotional abuse and severe trauma after witnessing their father stab their mother. The children are currently living with their maternal aunt under the care of the Local Authority. The DARDR Panel consists of representatives from professional services who contributed to the rapid review.
10. The rapid review identified nine lessons learnt and a plan with timescales for improvement. Appendix A.

11. The DARDR reconvened 29 June 2023 following the conclusion of the court proceedings. During the first Panel meeting the scope of the Review was discussed and agreed by the Panel as January 2015 to 19 May 2022. The timeframe was agreed by the Panel based on Mahal's removal from the sex offenders register and the subsequent end of supervision by the Probation Service. The review includes any relevant facts from earlier periods of Wafiya's life.
12. There were no immediate or urgent interventions or actions identified by the Panel members. All the Panel meetings were recorded and the minutes circulated to the members for the amendments and agreement. This was the process throughout the review. Actions were recorded and checked for completion during the next meeting.
13. Draft Terms of Reference (ToR) and the agenda were circulated to potential Panel members prior to the first meeting. The Terms of Reference were discussed by the Panel, during the first few meetings. The ToR were reviewed during each meeting and finalised during the Panel meeting on 26 September 2023 (Appendix B). Chronological reports were commissioned from all identifiable representatives. The membership of the Panel was regularly reviewed.
14. The second panel meeting was convened 22 August 2023 where the chronologies and actions were discussed by the Panel members. As a result of the discussions Individual Management Reviews (IMRs) were commissioned by the agencies who had relevant contact with during the agreed timeframe.
15. A third Panel meeting was convened on 26 September 2023, where the IMRs were discussed by the Panel. The IMRs were completed by an independent author. There were four further panel meetings. The draft report of the Review was discussed at the meeting in September 2024. The finalised report was agreed on (date June 25) by the DARDR Panel.
16. There were a number of delayed submissions of chronologies and IMRs which led to additional meetings. A number of the contributors to the Review were managing changes in their organisational structure resulting in additional responsibilities and workloads. These had an impact on their ability to attend the meetings and the deadlines for submission of reports.

Confidentiality

17. The content and findings of this review will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

18. The Government Protective Marking Scheme (GPMS) was adopted throughout the review. The documents produced and shared during the process of the review were password protected and only available to participating members. Where possible the Criminal Justice Secure email (CJSM) was used.

19. Bahija was invited to select alternative names for her family but chose not to respond. The following pseudonyms have been used in this review to protect the identity of those involved.

Name	Who	Ages	Ethnicity (if known)
Wafiya	Victim	34	Indian
Mahal	Perpetrator	32	Asian British Pakistani
Imran	Victim's child		Asian British Pakistani
Farah	Victim's child		Asian British Pakistani
Bahija	Victim's sister	N/K	Asian British Pakistani
Hina	Mahal's mother	N/K	N/K
Hamza	Mahal's brother	N/K	N/K
Friend 1	Friend	N/K	N/K
Friend 2	Friend	N/K	N/K
Friend 3	Friend	N/K	N/K

Terms of Reference

20. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified.

21. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion.

22. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel. Any parallel investigations to be identified.
23. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required.
24. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings.
25. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it.
26. To identify how the review should take account of previous lessons learned in Newham Borough Council and from relevant agencies and professionals working in other Local Authority areas.
27. To identify how people in Newham Borough Council area gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.
28. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations.

Panel Considerations

29. Could improvement in any of the following have led to a different outcome for Wafiya, considering:
 - a) Communication and information sharing between services with regard to the safeguarding of adults and children
 - b) Communication within services

- c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

30. Whether the work undertaken by services in this case are consistent with each organisations:

- a) Professional standards
- b) Domestic abuse policy, procedures and protocols

The response of the relevant agencies to any referrals from January 2015 relating to Wafiya and Mahal. It will seek to understand what decisions were taken and what actions were or were not 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 with Wafiya and Mahal.
- 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 any risk assessments undertaken by each agency in respect of Wafiya and Mahal.

31. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

32. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

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

34. Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

35. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Methodology

36. Domestic Abuse Related Death Reviews (DARDRs)* were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. A review was commissioned by Newham Council in.

37. The review has followed the 2016 Statutory Guidance for Domestic Abuse Related Death Reviews. The circumstances of Wafiya's death initiated a discussion on whether there was sufficient guidance within the Statutory guidance where the circumstances of the death are not immediately associated with domestic abuse.

38. The IMRs were quality assured and supervised by their respective agency by the original author and Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

Contributors to the Review

Agency	Chronology	IMR
Newham Community Safety Partnership	No	No
Department of Work and Pensions	Yes	No
Barts Health NHS Trust	Yes	Yes
North East London ICB	Yes	Yes
Adult Social Care		
Change Grow Live (CGL) Newham Rise	No	No
ELFHT East London Foundation Health Team	No	No
Black Women's Project	No	No
Redbridge Children's Services	Yes	Yes
London Ambulance Service	No	No
Metropolitan Police SCRG	Yes	Yes
London Borough Newham Homeless Prevention Service (HPAS)	Yes	No
Education	No	No
Newham Children and Young People's Service	Yes	No
Victim Support	Yes	No
Hestia	No	No
Newham Children's Social Care	Yes	Yes
London Ambulance Service	No	No

39. There were sufficient independence and expertise on the panel to examine the events and prepare an unbiased report safely and impartially. The panel chair is

satisfied the chronologies and IMRs have been produced with independent oversight from the panel member. None of the panel members had any involvement with the family.

The Review Panel Members

40. The following agencies and representatives contributed to the review.

Name and position	Organisation
Sharmeen Narayan - Domestic Abuse/Sexual Violence Commissioner	Newham Borough Council
Laura Anderson - Advanced Customer Support Senior Leader	Department of Work and Pensions
Kate Gray - Named Professional for Adult Safeguarding	Barts Health NHS Trust
Emma Tukmachi - Named GP for Adult Safeguarding, Newham	North East London ICB
Paula Purcell – Practice Manager	Redbridge Children’s Services
Beverley Halligan - Head of the Newham Social Care Academy and Principal Social Worker, Children and Families	Children and Young People’s Service
Raman Bhangoo – Case Worker	Victim Support
Katie Burgess - Snr Safeguarding Governance Officer	London Borough of Newham Adult Social Care
Scimone Green - Senior Pathways Manager	Homeless Prevention Advice Service
Sally Pattison – Detective Sergeant	Specialist Crime Review Group
Ameliah Rayn - Education Safeguarding Lead Newham	Newham Borough Council
Joy Ogundayisi - Practice Learning Reviewer	Newham Children’s Social Care
Ilona Benjamin – Homicide Advocate	Victim Support
Eloise Simpson - Quality & Governance Lead	Change Grow Live Newham Rise
Dawn Mountier - Safeguarding Officer Quality Directorate	London Ambulance Service

Dissemination

41. The organisations/representatives of the panel will receive a copy of the report after any amendment following the Home Office’s quality assurance process. A copy will be provided to Wafiya’s family, the Mayor for London and the Domestic Abuse Commissioner.

Author of the Review

42. Derrick Laing is an independent chair and author working on behalf of Sancus Solutions Ltd. He was commissioned as the Independent Chair and Author by Newham Borough Council in June 2022 having had no working relationship with any agency in Newham and any involvement in the Review.
43. He has experience as a practitioner, manager and senior investigating officer in the police with responsibility for area crimes including domestic abuse, safeguarding and sexual offences.
44. He has worked with partners through the MASH and MARAC. He has also worked with Mental Health agencies to review cases under the Mental Health Act 2007 to improve best practice using police resources.
45. He is currently the chair for four separate Reviews. He has completed the Home Office DARDR* online training and attended a number of Advocacy After Fatal Domestic Abuse (AAFDA) events as part of his continual development and improvement.
46. A full background and independence statement at Appendix B.

Parallel Reviews

47. On 20 June 2022 Newham Safeguarding Children Partnership initiated a Rapid Review in accordance with Working Together 2018 to consider the safety of the children following their exposure to the traumatic death of their mother. A considerable number of the organisations involved in the Rapid Review are represented in the DARDR Panel.
48. The children are currently living with their maternal aunt under the care of the Local Authority. Members of the Rapid Review provided a summary of their agency's involvement. The identified learning and good practice feature in the action plan with identified owners and timescales.
49. The Metropolitan Police completed a death or serious injury following recent police contact referral to the Independent Office for Police Conduct (IOPC) in May 2022. DSI Operation Vaigai was the name given to the IOPC investigation, which was completed in May 2023. The investigation concluded that there was no indication

any police officer had behaved in a manner that would justify the bringing of disciplinary proceeding or had committed a criminal offence.¹

50. On 13 May 2023 the IOPC submitted their eight recommendations to improving policing and public confidence in the Metropolitan Police complaints system and prevent a recurrence of similar incidents. The Metropolitan Police accepted all the recommendations, which have been actioned between 2024 – 2025.

Equality and diversity

51. The Chair of the Review and the Panel did take into consideration the nine protected characteristics under the Equalities Act 2010, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Age

52. Wafiya was 34 at the time of her death. Mahal was 32. Data from the National Police Chiefs' Domestic Homicide Project annual report 2024 states of 242 domestic abuse related deaths recorded between April 2022 to March 2023, 80 were intimate partner homicides. The majority of victims being female aged 25-54 years old, and majority of perpetrators being male and of the same age bracket²

Disability

53. Section 6 of the Equality Act 2010 describes disability if you have a physical or mental impairment. Your impairment has a substantial and long-term adverse effect on your ability to do normal day-to-day activities. Mahal had been receiving mental health support for over ten years. He had regular treatment and professional support. There was little or no support from his family and he relied solely on Wafiya, who received additional financial support as his carer.

54. Mahal struggled with severe mental health issues that often required constant support. Wafiya was balancing her responsibilities as a mother with the demands of being Mahal's full time carer. Despite enduring incidents of coercive control and domestic abuse, Wafiya ensured the children maintained a relationship with their father.

55. In a SafeLives Spotlight series (2016-19) it highlighted victims of domestic abuse aren't hiding from services – it's the system that fails to see them. We know this can feel particularly true for parents who are experiencing domestic abuse and

¹ <https://www.policeconduct.gov.uk/our-work/learning/police-contact-woman-and-her-partner-prior-womans-death-metropolitan-police>

² NPCC- Scale of homicide and suicides by domestic abuse victims revealed

engaging with agencies like children’s social care. We know that a failure to see the whole picture for the whole family can sometimes mean that the needs of the adult victim are missed – and the perpetrator remains invisible and unchallenged³.

Gender assignment

56. This was not relevant to the review.

Marriage and Civil partnership

57. The panel has not been able to establish how long Wafiya and Mahal had been together before they married in the UK. Wafiya informed her sister that she had married Mahal at short notice and without the family’s knowledge. They wanted to ensure they were married before their first child were born. It is not known whether Wafiya was already pregnant when they married.

58. Mahal’s family voiced their disagreement with the marriage and didn’t accept Wafiya into the family. In India the marriage between a Muslim male and Hindu female is not valid under Muslim personal law and will be deemed irregular.⁴ This could be the basis of the family’s disapproval, but this has not been established.

59. The review has heard how Wafiya’s family were unhappy about the marriage without their knowledge. The acceptance of interfaith marriages is becoming more common, both in absolute numbers and as a proportion of all marriages. The 25 districts with the highest proportion of religiously mixed marriages are nearly all found in London⁵. The impact on the families cannot be underestimated and can lead to resentment. The panel were unable to identify whether Mahal’s personal religious views influenced his domestic abuse. This is a consideration for future reviews.

Pregnancy and maternity

60. In August 2012 the Jigsaw Team made a referral to Newham Children’s Social Care after discovering Wafiya heavily pregnant. Following Imran’s birth Newham Children’s Social Care held a strategy meeting to determine the level of support to provide the family. A Child Protection Conference was held and determined the family will be subject of a Child In Need Plan. The family moved out of the area and the plan was transferred to Redbridge Children’s Social Care. The Child Protection plan was in place to October 2016.

³ <https://safelives.org.uk/resources-for-professionals/spotlights/spotlight-parenting-through-domestic-abuse/>

⁴ <https://www.indiatoday.in/law/story/marriage-inter-faith-couple-hindu-muslim-boy-girl-muslim-law-mp-high-court-special-act-2545744-2024-05-30>

⁵ <https://dam.ukdataservice.ac.uk/media/604843/voas.pdf>

Race, Religion or Belief

61. The decision to marry is shrouded in unknown information. According to Bahija, Wafiya chose to convert to Islam to marry Mahal. There is no indication that she was under any pressure or coercion to agree to the change of religion. The Changing Landscape of Faith in Britain: Rebirth, Renewal and Reimagining 2025 described religion in Britain as in transition rather than decline.⁶ One of the key points from a recent study into 'Britain's attitudes to faith in public life – May 2024' There is a perception that the UK welcomes religious diversity (60% of the sample agreed compared to 26% who disagreed) and that good relations exist between faith groups (73% of the sample report having friends of different faiths).⁷

Cultural Factors

62. As part of the review the panel considered the involvement of independent cultural specialists experienced in different faiths, religions and interracial relationships. This formed considerable discussion during the early panel meetings. The panel members outlined their background in terms of cultural heritage, religious affiliation and professional experience to ensure a balanced representation. The chair was satisfied that there was sufficient diversity, cultural and religious experience within the panel to evaluate the information with transparency.

Gender and Sexual Orientation

63. The services involved in supporting the family had not identified any domestic abuse prior to the fatal incident. Wafiya is signposted to local domestic abuse service providers, but there's no indication she utilised these facilities. The Office for National Statistics (ONS) published its annual domestic abuse data bulletin, with figures for the year ending March 2023 showing that one in four women (27%) experienced domestic abuse since the age of 16⁸ The same bulletin also contains data on domestic homicides, which do clearly show the gendered nature of domestic abuse. Homicide Index data from the year ending March 2020 to the year ending March 2022 shows that 67.3% of domestic homicide victims were female. Of the 249 female domestic homicide victims, the suspect was male in a staggering 241 cases. In the majority of female domestic homicides, the suspect was a male partner or ex-partner (74.7%), whereas in the majority of male domestic homicides, the suspect was a male family member (66.1%).

⁶ <https://iifl.org.uk/wp-content/uploads/2025/12/Report-The-Changing-Landscape-of-Faith-in-Britain.pdf>

⁷ <https://iifl.org.uk/reports/britains-attitudes-to-faith-in-public-life-may-2024/>

⁸ <https://www.womensaid.org.uk/who-is-missing-in-the-data-what-the-available-data-on-domestic-abuse-does-and-doesnt-tell-us-about-womens-experiences/>

64. Furthermore, the total number of women killed by a partner/ex-partner over this three-year period was 186. All the suspects were male. This is an average of 1.2 women per week killed by a male partner/ex-partner. In previous years, this average has been around 1.5 women per week, but homicide data changes year-on-year, so a longer-term analysis would be needed to establish a trend. Similarly, regardless of whether there is a trend or not, the stark reality remains that each week, a woman is killed by a man – the grief and devastation this leaves is unimaginable, as each woman is someone’s daughter, mother, sister, or cherished friend and each loss is an immense tragedy.⁹

Involvement of family and friends

65. In May 2022 Newham Community Safety Partnership informed Wafiya’s sister Bahija of the commencement of the DARDR following her sister’s murder. The Victim Support Homicide Advocate supporting the family reported family’s willingness to engage in the process. A copy of the DARDR Home Office leaflet was sent to the family.

66. In June 2023 the Newham CSP lead contacted the Victim Support Homicide Advocate to explore how the family would like to participate in the DARDR process following the conclusion of the court proceedings. The advocate confirmed Bahija wanted to participate in the process and would be happy with an online meeting.

67. A virtual meeting was arranged for 13 July 2023. The Newham Domestic Abuse Commissioner and Chair of the DARDR met with Bahija who was supported by the Victim Support Homicide Advocate. Bahija provided historic information on the background of their family. How she looked up to her sister who she describes as a ‘great role model.’ She said Wafiya’s death left the family traumatised. She was happy to provide the details of Wafiya’s work colleagues who she knew were keen to provide background information regarding Wafiya’s domestic abuse and the injuries she sustained.

68. In September 2023 Wafiya’s friends who provided witness statements as part of the murder investigation were sent a letter notifying them of the DARDR and inviting them to contact the Chair. On 17 October 2023 the Victim Support Homicide Advocate informed the CSP Lead that Bahija’s brother was keen to be involved in the review but was away travelling on business. Follow up emails were sent at the end of October and in November 2023. Bahija replied saying he was still travelling on

⁹ <https://www.womensaid.org.uk/who-is-missing-in-the-data-what-the-available-data-on-domestic-abuse-does-and-doesnt-tell-us-about-womens-experiences/>

business and was too busy. The Chair requested the details of Wafiya's friends. Bahija confirmed by email that they preferred not to be involved.

69. Bahija has voiced concerns regarding the long-term support for the children and her ability to provide permanent care for them. This was her priority. She has not responded to correspondence regarding the use of the pseudonyms and updates on the progress of the review. The panel respect her views and her focus on building her relationship with her new family.

Introducing Wafiya

70. Wafiya's profile is based on Bahija's account of their family background and what she knew about her sister's relationship with Mahal (Appendix C). The information provided by the panel professionals and agencies who had contact with her during the review period is covered in their IMRs.

71. Wafiya was born in the UK and had a younger sister, Bahija and younger brother. When they were young their mother was diagnosed with a brain tumour, which left her paralysed and bed bound. Wafiya took responsibility for bringing up her siblings as her father was always working. Bahija explained how they fought like sisters and loved like sisters. She described Wafiya as 'a great role model.' Bahija explained how her sister was known to the family by a different name.

72. Wafiya and Mahal met in a nightclub. According to Bahija they dated for some time before it became serious. Wafiya did not disclose her pregnancy to her family. It is not known whether the pregnancy was planned. Bahija described how Wafiya phoned her to say she had married Mahal, changed her name and needed to collect documents from home to make it legal. She didn't think her sister realised how upsetting her actions were to the family.

73. Wafiya informed her wider family that she had converted to Islam and intended to move away to start a new life. Her parents were happy for her to stay at their home with the baby. Mahal's family were not happy with the relationship or that Wafiya had converted to Islam. For the first few years after their marriage, they lived with Mahal's parents until they were able to get their own home in Newham. When they were living with his parents Mahal wasn't always allowed to stay in the house. He slept in the car for 6 months because his mother wouldn't let him in the house. According to Bahija, Mahal's family didn't want to help or support him. Wafiya always made an effort with Mahal's family. She was trying to get him help.

74. As the relationship continued Wafiya learned about Mahal's background including his mental health history and not being allowed around children because of his

sexual offence conviction against two females. Wafiya shared some of the details with her sister but not the rest of the family.

75. Wafiya and Mahal had two children. Imran and his sister Farah. At the time of their mother's murder, they were aged nine and eight respectively. They were living in Newham in housing provided by Newham Homeless Prevention Advice Service (HPAS). Mahal stopped working after their daughter was born. According to Bahija he was on medication for his mental health.
76. The children were placed on a Child in Need Plan in March 2015 by Redbridge Children's Services, due to concerns about Mahal's deteriorating mental health and the risk to the children following his sexual offence conviction.
77. Bahija explained how Wafiya and Mahal were invited to family events. Mahal would be selective about the ones he attended. He attended their mother's Hindu funeral, which she believed was difficult for him as a Muslim. When they had any family gatherings the family would make an effort with the right food to make him feel welcome, but he wouldn't speak to them. Wafiya continued to struggle financially but tried to ensure the children had gifts at Christmas.
78. Wafiya informed her sister that Mahal would sometimes disappear with the car leaving her to take the children where they needed to go by public transport. This made her life very difficult. Wafiya was struggling financially. Mahal was not providing her with financial support for the children even when he was working.
79. In May 2016 Mahal left the family home due to concerns about the risk to the children. Wafiya was upset that the children would not see their father and worried how she was going to cope financially as the benefits would be reduced.
80. Wafiya had disclosed to a work colleague her difficulties with the relationship with Mahal and how she was concerned about his behaviour which had worsened. She talked about her financial difficulties a few months before her death. Around two weeks before her death she informed a work colleague that she had had enough and was taking the children away to start a new life.
81. Wafiya's father rang her regularly during the fifteen days before her death, but she was too busy. On one occasion Mahal returned from work and accused Wafiya of having an affair. He grabbed her hair and caused a black eye. Wafiya messaged a friend, saying she needed to "tell my story to someone" who "might help or just listen". She thought that, if the kids had not been present, "he would have killed her". She said that she feared Mahal who was unpredictable and would "flip out".

82. Bahija stated that she was not aware of any domestic incidents and had not witnessed any injuries to her sister when they met or face timed each other. She knew her sister was hiding things from her.
83. She described how their mother used to make them go to the mosque to learn about the Muslim religion. She said, “We were taught to be loving and caring and had an extremely strong bond. Wafiya’s daughter had said “I am upset with what dad did; I really miss mum”.
84. She stated, *“Wafiya showed her children so much love. She was now continuing the rituals of Father’s Day and other events so the children can continue what she started. Her husband didn’t show the love to the children as she did. He showed his bad side to them. She was always protective of the children.”*

Introducing Mahal

85. Mahal has a forensic history since 2007. In 2010 he was convicted of two incidents of sexual assault with one victim being only 15 years of age. He was placed on the sex offenders register for five years. During his time on the sex offenders register he was supervised by Newham Probation Service and the Newham Jigsaw Team¹⁰.
86. Mahal’s mother and brother live in Ilford. He also had a sister. The panel has not been able to obtain sufficient background information on Mahal’s family and their relationship. Mahal was known to North East London Integrated Care Partnership since 2011. They provide joint health and care services in the NHS. In February 2014 he referred himself to the Newham mental health team on the advice of his probation officer. He could not maintain eye contact. He reported having a poor appetite, and sleep. His mood was low moderate to severe depression. No psychotic episodes. No suicidal ideations or thoughts elicited. He denied thoughts of harming others including his son.
87. His medical records indicate anxiety and a history of drug abuse. The panel has not been able to establish whether drug abuse relates to illicit or prescribed medication. In 2013 he attended the GP surgery on multiple occasions with low mood and feeling guilty about the sexual offences he had committed. He was referred to talking therapies and started on medication but with poor compliance. He declined counselling.

¹⁰ Metropolitan Police Sex Offenders and Dangerous Offenders team

88. On 18 February 2015 Wafiya called the police as Mahal was hitting himself. He was subsequently taken to King George's Hospital. The next day Children's Social Care made a referral to the police as Mahal had admitted to a number of sexual offences against minors. The reported incidents were investigated. No further action was taken. Due to the nature of these disclosures, appropriate referrals were made to children services. As a result, police and social workers conducted joint visits.
89. On 19 February 2015 Mahal attended King George Hospital in an agitated state. He claimed to have assaulted Wafiya. He disclosed that he was a serial sex offender. Wafiya was instructed not to leave him alone with the children. She signed a safeguarding agreement not to leave the children with Mahal due to his previous sexual offences. The hospital completed a referral to Redbridge Children Services. There's no indication that a referral was made for Mahal for additional support.
90. Mahal's mental health continued to deteriorate. He became withdrawn and was waiting on counselling from mental health services. During a social worker visit on 26 February 2015, Wafiya described Mahal as withdrawn and doesn't feel worthy of being part of the family. He presented as deeply depressed; no eye contact and did not speak, nodded, or shook his head in response to questions.
91. In March 2015, Mahal's children were assessed by Redbridge Children's Services and placed on a Child Protection Plan due to emotional abuse. The family received announced and unannounced visits by the social worker to their home to review the welfare of the children.
92. There were two further incidents where Mahal attended a police station wanting to confess to crimes. In April 2015 he was sectioned under 136 of the Mental Health Act and taken to Goodmayes Psychiatric Hospital for treatment.
93. Mahal was prescribed venlafaxine (antidepressant) and olanzapine (mood stabiliser also used as an antipsychotic) for recurrent depressive disorder. He was receiving mental health support from the Home Treatment Team¹¹ In 2015. On 23 June 2015 Mahal presented at Forest Gate Police Station, terribly upset and crying. He was initially taken to Newham Hospital before being transferred to Goodmayes Psychiatric Hospital for an assessment.
94. Mahal often struggled to engage with the social worker. He was distant, quiet and would not make eye contact. He was receiving venlafaxine for his depression, but he

¹¹ The Home Treatment Service provides assessment and treatment to people who are experiencing a mental health emergency of nature or severity that would otherwise require admission to inpatient services.

expressed his wish to stop taking it. Wafiya was asked to encourage him to continue with the medication. In November 2015 his GP referred him to Redbridge Home Treatment Team who completed daily visits to ensure he continued with his medication. Mahal was the subject of an assessment to consider his risk of sexual re-offending by Jigsaw.

95. In January 2016 Mahal's mother visited the family. She told Mahal to make sure his children didn't become like him. Mahal reacted by attending A&E King Georges Hospital and asked to be admitted as he did not feel that he was good for the children. He was sent home where he took an overdose of two weeks' worth of his prescribed medication. He was admitted to hospital but released after 14 hours. There's no record of a referral to children services, or mental health services.
96. During the visits by social worker Mahal would usually be in his room not with Wafiya or the children. On 29 April 2016 an Independent Parenting Assessment concluded, 'Mahal had disengaged in any meaningful sense from parenting his children and his disclosures of wide-ranging sexual offences should be taken seriously. Mahal is draining the emotional life of the family.'
97. In May 2016 the Jigsaw assessment concluded that Mahal was high risk of sexual recidivism. Wafiya was instructed to arrange for Mahal to leave the family home. He would only have access to the children in a supervised environment. Mahal moved to his mother's address in Newham. In June 2016 Mahal was reported as sleeping rough by Troubled Families. He was referred to Street Link¹²
98. On 16 November 2016 Wafiya reported that Mahal had taken an overdose of prescribed medication. He was detained under the Mental Health Act for 28 days. He was admitted to Newham Hospital for observation and treatment. This was followed up on discharge by his Consultant in Outpatients.
99. On 20 March 2017 the social worker carried out an unannounced visit. Wafiya reported that Mahal had gone back to Pakistan with his mother for a month. When he returned, he had regular contact with the children but was not allowed to stay at the home address.
100. Mahal's mental health concerns continued. He was known to the enhanced mental health service for depression and was an in-patient in 2016 at the centre of Mental Health. He was diagnosed with recurrent depressive disorder and Selective

¹² Connecting people sleeping rough to local support services

Mutism¹³ and later discharged from Community Resolution Treatment Team (CRT) North on 8 June 2017, to the Enhanced Primary Care Mental Health Service (EPCLS). In June 2018, he presented himself at Newham University Hospital emergency department with suicidal ideation.

101. Mahal was assessed June 2017 by the Rapid Assessment Interface and Discharged (RAID) team. During the assessment he described that he felt like giving up, struggled to get out of bed and had a strained relationship with his wife, who he thought was judging him and not happy in their marriage. He added that he works long hours as a traffic marshal in a car park in the city; thus, sleeping limited hours. He had recently stopped taking his anti-depressant medication. The risk of harm to himself and others was deemed to be low. He was discharged to his mother's address with Outpatient follow up at Community Recovery Team. He declined a therapy referral.
102. On 23 June 2018 Mahal took an overdose of his antidepressant medication. He was taken by ambulance to Newham University Hospital where he was selectively mute, not disclosing how many tablets he had taken. He was assessed the following day and admitted to the Critical Care Unit for further treatment of the overdose. He informed the psychiatric team that he was low as he could not live with his wife and children. Mahal expressed his regret for taking the overdose and asked to be admitted to the mental health unit to recover. After a brief period in hospital, he was discharged to the care of the Home Treatment Team where he received psychology input as well as daily visits. He was discharged to the outpatient clinic.
103. Mahal had been living at his mother's address since May 2016. His brother Hamza was also living at the address. In May 2019 Mahal argued with his mother about the living space. Mahal's brother joined the argument, which resulted in the police being called and an allegation that Mahal had picked up a knife during the argument. When Police spoke to the family, they denied this had occurred.
104. On 29 October 2020 there was another incident with his brother leading to Mahal's arrest for threatening his brother with a knife. He was taken into police custody where he was interviewed with an appropriate adult present. He denied the allegations claiming his brother was drunk and started swearing at his mother and the children. His mother came to the police station and provided a statement stating Hamza was drunk and he lied about the incident.

¹³ Selective mutism is an anxiety disorder where a person is unable to speak in certain social situations. A child or adult with selective mutism does not refuse or choose not to speak at certain times, they're literally unable to speak.

105. In March 2022 Mahal was struggling with his mental health and contacted an online GP service seeking help and support.

106. On 10 May 2022 Mahal and Wafiya had an argument over finances. The police attended after receiving an anonymous call. Mahal conformed they had argued about an unpaid tax bill. Mahal replied “no” or declined to answer the DASH question. Neither Wafiya nor Mahal consented to being referred to support agencies.

Interview with Mahal

107. In December 2023 Mahal was invited to an interview with the chair of the review. He was informed by the prison probation officer and agreed to participate. The prison probation officer reported that Mahal gets really emotional, has poor literacy and significant mental health issues (anxiety, limited understanding and personality disorder). He advised the use of video link in case he subsequently decides to disengage.

108. On 28 February 2024 Mahal was video interviewed supported by the prison probation officer. The probation officer explained prior to the meeting that Mahal seen earlier that day and was aware of the appointment and was happy to attend. He was referred to John Howard Hospital (medical secure hospital) on 6 October 2022. He was sectioned for hearing voices, and a psychiatric report was completed by Dr Birbeck on 30 June 2023 to assist with sentencing. It highlighted that his risk was not driven by a psychotic mental state but anti-social personality with an ingrained propensity for violence. There was no evidence of a severe and enduring mental illness.

109. It was exceedingly difficult to hear Mahal talking as he whispered his responses. He did not look at the camera and spent a lot of time using his hands to try and explain what he wanted to say. Using closed questions, the Chair ascertained that Mahal had been having mental health issues for ten years. That he was prescribed venlafaxine and olanzapine medication, but he didn't think it was the right ones, but it did help.

110. When asked whether he spoke to anyone about his mental health problems he nodded replies suggesting he was required to see someone in hospital on a weekly basis. He became visibly upset but confirmed talking helped and he went home after the sessions. His family provided help and support.

111. He indicated that about a month before the murder he was made to stop taking his medication. He said he was not offered an alternative and he didn't ask to start

taking the medication again. He could not say who had told him to stop taking the medication. When he was asked if he had anything to say he said, “*I’m not well in the head.*” The prison probation officer commented that the meeting was a typically poor presentation by Mahal, and that there seemed to be an element of acting.

Background Information

112. Wafiya and Mahal had been married for around 10 years. In May 2022 they were living together with their children in a home provided by London Borough of Newham Homeless Prevention Service. In May 2022 Mahal called the police stating he had stabbed his wife and she wasn’t breathing. His two children witnessed the murder.

113. Police officers and London Ambulance Service (LAS) arrived on scene with Helicopter Emergency Medical Service (HEMS) also attending, due to Wafiya having suffered multiple stab wounds. Emergency lifesaving attempts were unsuccessful, and Wafiya was pronounced dead at the scene.

114. A forensic post mortem examination took place on 21 May 2022 at East Ham Mortuary. Wafiya sustained multiple stab wounds with severe force being used. She had stab wounds to the neck which had nearly severed the spinal cord. Wafiya sustained approximately 30 wounds over the body and had lots of defensive injuries. An Inquest was opened and adjourned pending the outcome of the criminal trial.

Combined Narrative Chronology

115. The chronologies provided by the agencies involved in the review cover the background information and events, which occurred during the agreed timeframe. It outlines the agencies’ involvement with Wafiya and Mahal, and the information known to them. The details are taken from the Panel’s initial chronologies and those that completed IMRs.

116. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the primary source of information.

Organisation	Role	Preface
Redbridge Children’s Services	Children’s Services	RCS
Metropolitan Police Service	Police	MPS
Department of Work and Pensions	Financial Advice and Support	DWP
North East London ICB	GP	GP
Newham Children Social Care	Newham Children’s Services	NCSC
East London Foundation Trust: Adult Mental Health Team	Mental Health Services	ELFT

London Borough Newham Homeless Prevention Service	Housing	HPAS
Doctor Care Anywhere	Private GP Service	DCA
Barts Hospital NHS Trust	Barts Hospital	BH

Prior to the review period

FEBRUARY 2014

117. **RCS.** 3 February received a referral from King George Hospital Ilford Mental Health Team after Mahal had self-referred on the advice of his probation officer.
118. **RCS.** 5 February 2014 a home visit was completed by the social worker. Mahal was present and observed to be depressed and downcast. He knelt on the floor and refused to have any eye contact during the visit.
119. **RCS.** During a strategy meeting in March 2014, it was recognised that the family accommodation was unsuitable.

APRIL 2014

120. **RCS.** On 20 April the social worker visited the family home. Wafiya had just given birth to her daughter Farah. The home environment was described as clean and tidy. The case was reviewed by a manager who decided to close the case.

OCTOBER 2014

121. **RCS.** Wafiya and Mahal's children were assessed by Redbridge Children's Services and placed on a Child Protection Plan due to emotional abuse.

During the review period

FEBRUARY 2015

122. **RCS.** Referral submitted to MPS after Mahal admitted to a number of sexual offences against minors. The reported incidents were investigated and unsubstantiated. No further action was taken.
123. **RCS.** On 19 February received a referral from King George's Hospital. Mahal had attended the hospital in an agitated state and claimed to have slapped Wafiya.
124. **RCS.** Wafiya signed a safeguarding agreement not to leave the children with Mahal due to his previous sexual offences.

MARCH 2015

125. **MPS.** 3 March 2015 Mahal contacted the police Jigsaw team because he didn't want to live at the family home anymore. He was found outside Ilford Police Station and taken voluntarily to King George's Hospital

126. **RCS.** Completed a Section 47 child protection enquiry to review the safeguarding concerns for the children. The children were made the subject of a Child Protection Plan.

APRIL 2015

127. **MPS.** Mahal attended Ilford Police Station as he felt depressed and had a "guilty conscience" stating that he was wanted for robberies that occurred several years ago. He was detained under Section 136 Mental Health Act.

JUNE 2015

128. **DWP.** Mahal made an application for a Personal Independence Payment (PIP) as he had suffered from depression since 2013.

129. **MPS.** Mahal attended Forest Gate Police Station wanting to confess to crimes that he had committed. The police contacted Wafiya who stated that due to his depression he felt he was not a good influence on the children.

OCTOBER 2015

130. **RCS.** On 26 October the social worker informed Wafiya that their manager requested an independent assessment of her ability to protect the children, which she agreed to.

NOVEMBER 2015

131. **GP.** Mahal referred to Redbridge Home Treatment Team who completed daily visits to ensure he continued with his medication.

JANUARY 2016

132. **MPS and NCSC.** Joint home visit with Newham Children's Social Care staff to check on the welfare and risk to the children. Mahal was present but did not participate in the meeting. Wafiya was aware of Mahal's sex offences and stated he had been diagnosed with depression and was receiving visits twice a week from Goodmayes Community Outreach Team¹⁴

¹⁴ The community treatment team (CTT) works with adults in the community with an acute physical need who could potentially be treated at home, rather than attend accident and emergency (A&E).

133. **MPS.** Mahal attended Ilford Police Station saying he was a registered sex offender and homeless. He stated that he had separated from Wafiya. The police spoke to Wafiya who denied the separation.

134. **NCSC.** There were 14 reported engagements in 2016 including six visits by the social worker. The family were also receiving support from a Troubled Family social worker.

FEBRUARY 2016

135. **RCS.** Social worker informed Wafiya that they were arranging an independent assessment of the care for of the children.

MAY 2016

136. **RCS.** Wafiya voiced her concerns to the social worker following the independent assessment, which she had discussed with Mahal. He did not want to be accused of sexually abusing his children. It was recommended that the Redbridge Children's Service social worker and Troubled Families Social worker complete a joint visit with the family.

JULY 2016

137. **GP.** Wafiya informed the GP that Mahal was no longer living with the family. She reported that social services were involved and that the children were coping well. The family visited Mahal once a month. The GP had a lengthy conversation with Wafiya suggesting she let the GP know if she has any concerns.

OCTOBER 2016

138. **RCS.** Child Protection Conference occurred on 5 October 2016. The children were reduced from a Child Protection Plan to a Child In Need Plan in December 2016. They would continue to receive support from Troubled Families for six weeks. The case was closed to Redbridge in May 2017, and a letter was sent to the parents.

DECEMBER 2016

139. Mahal was discharged from the Newham Centre for Mental Health on the 20 December 2016. He received follow up care from the Community Recovery Team and was review by the Consultant psychiatrist in in February 2017 where he was found to be well and referred on to the Enhanced Primary Care Liaison Team.

NOVEMBER 2017

140. **NHPAS.** Received an application from Wafiya for emergency housing support after she was evicted from the family home due to rent arrears. She was advised to make a new housing application in her name instead of Mahal's.

141. On 20 November Wafiya submitted her housing application to remain at the property in Ilford with her children. She was required to leave the property in November but was offered a property in Stratford.

JUNE 2018

142. **BH.** On 23 June Mahal was taken to Newham University Hospital after taking an overdose of venlafaxine, with suicidal intent. He stopped taking his anti-depressants as the pharmacy had given tablets instead of capsules and he didn't take them during Ramadan.

JUNE 17 – JULY 2018

143. **ELFT.** Mahal received mental health support by enhanced primary care liaison. Enhanced primary care liaison are a bridge service between ELFT secondary care and GP.

JANUARY 2019

144. **NCS.** Wafiya enquired when Mahal would be allowed to move back in with the family.

MAY 2019

145. **MPS.** Attended non crime domestic incident between Mahal and his brother at their mother's address. The incident was recorded; no action was taken.

JULY 2019

146. **GP.** Family registered at Church Road Surgery. During the patient health check Wafiya stated that Mahal doesn't always talk and suffers from depression. It had been like this for two years now. Mahal admitted to selective mutism.

OCTOBER 2019

147. **NCS.** Following a number of meetings with the family and professionals the Children In Need Plan was closed after all the concerns were addressed except for permanent housing.

SEPTEMBER 2020

148. **ELFT.** On 7 September Mahal had a mental health review. He reported feeling stable and working as a civil servant. He reported he had no suicidal thoughts intentions or plans.

OCTOBER 2020

149. **MPS.** Arrested Mahal following an allegation he had threatened his brother with a knife. No action taken as his mother informed the police that the incident had not happened.

NOVEMBER 2020

150. **GP.** Mahal seen in the surgery. He was reducing his medication. It was noted that his drug compliance was good and his mood stable. As part of the process of reducing his medication the GP had three telephone consultations with Mahal, December 2020, February 2021 and April 2021.

SEPTEMBER 2021

151. **GP.** Wafiya registered at Custom House surgery. During 2021 she made three visits to the surgery for consultations and blood tests. In December 2021 she was diagnosed with prediabetes and polycystic ovarian disease. She was prescribed medication.

MARCH 2022

152. **DCA.** Contact with Mahal. He reported having intermittent severe headaches and body numbness. He was concerned his food had been contaminated and he was being drugged. He did not feel that his wife was trying to harm him but thought he was going to die.

153. **NCS.** Received a referral from the Doctor Care Anywhere GP¹⁵ service raising concerns about Mahal's mental health. The online GP services completed a referral to The Multi-Agency Safeguarding Hub (MASH).

154. **NCS.** Single assessment with the family tasked for 16 May.

155. **NCS.** On 15 March 2022 the social worker visited the family and concluded that they appeared to minimise concerns pertaining to Mahal's mental health.

APRIL 2022

156. **NCS.** Home visit completed by the allocated social worker. The children said they were happy at school.

MAY 2022

157. **MPS.** 10 May, call from a neighbour reporting arguing from the home address. Wafiya and Mahal explained they were arguing about finances. A referral was made to NCS.

¹⁵ Doctor Care Anywhere is a private digital health service founded by doctors, providing an online medical assessment.

158. **NCS.** 14 May the social worker called Wafiya. She was offered domestic abuse support which she declined.

159. **NCS,** 16 May the allocated social worker completed an assessment. Both parents were observed responding appropriately to the children and was observed being affectionate towards the children. The assessment recognised the risks of substance abuse, mental health and Mahal's sexual convictions. The assessment recommended that the case is closed to social care.

Redbridge Children's Services

Prior to the review period

160. On 15 October 2013 Redbridge Children's Services (RCS) received a referral from Newham Hospital Social Care Team as Wafiya was pregnant with her second child. The family were informed of the transfer 26 October 2013. Mahal's sexual offence history was noted in the referral. Wafiya had reported her husband had never physically, verbally, or sexually harmed her or their son. A social worker was allocated to complete the initial assessment. They made three unannounced visits to the family home in December 2013 and January 2014 without a reply.

161. The allocated social worker completed a home visit in February 2014. Mahal was present and observed to be depressed and downcast. He was saddened that professionals were involved in his family. Both parents became emotional during the visit. Wafiya informed the social worker that she had changed her name by deed poll and had converted from Hindu to Muslim.

162. During a Redbridge strategy meeting in March 2014, it was recognised that the family accommodation was unsuitable for their needs. Mahal had lost his job and was struggling with feelings of guilt about the female victims of the sexual assault and kept crying. The attendees did not have any concerns for Aayan's safety. The decision not to progress to S47 enquiry was reached.

During the review period

163. During a visit from a social worker Wafiya described Mahal as deeply depressed and withdrawn because of his admission to sexual offences against females. Following the nature of these disclosures, appropriate referrals were made to children services. As a result, police and social workers conducted joint visits.

164. The family were subject to regular visits by a social worker. In July 2015 Redbridge Children's Services arranged a meeting with Wafiya's sister Bahija to discuss how she could support the family. Bahija believed her sister was coping well but might require some support when Mahal relapses as he did in February 2019. She recognised when her sister was overwhelmed as she (Wafiya) would rant when under pressure. She said Wafiya was very strong and does not give up easily. She explained that Wafiya contacts her for a chat when feeling down and sometimes she cries. She would visit her sister when she was overwhelmed. Bahija felt that the family should receive support to keep the family unit together.
165. During the visit in January 2016, Wafiya was aware of Mahal's sex offence history and stated he had been diagnosed with depression and was receiving visits twice a week from Goodmayes Community Outreach Team. Wafiya stated Mahal's mental state was slowly improving and she didn't consider him a risk to the children.
166. During a visit in January 2016, Wafiya informed the social worker that Mahal had taken an overdose of his prescribed medication following a visit from his mother. He had been admitted into hospital but was released fourteen hours later. Mahal was not seen as he was praying.
167. According to Redbridge Children Services records the assessment concluded that, 'Mahal had disengaged in any meaningful sense from parenting his children and his disclosures of wide-ranging sexual offences should be taken seriously. 'Mahal is draining the emotional life of the family.' Mr Hasan's disengagement and mental health are considered to heighten whatever risk exists and he should be cared for within the paternal family.' During a visit by a social worker in May 2016 Wafiya raised her concerns following the independent assessment.
168. The social worker reported that Mahal spoke to them for the first time since August 2015. He did not want to be accused of sexually abusing his children. It was recommended that the Redbridge Children's Service social worker and Troubled Families Social worker complete a joint visit with the family.
169. Mahal was required to leave the family home in May 2016 after being assessed as high risk of sexual recidivism or risk the children being taken into care by the Metropolitan Police Jigsaw Team. He went to live with his parents. Mahal would still visit the family home when the children were at nursery. It was the social worker's view that Wafiya lacked insight into Mahal's mental health and criminality, particularly his history of sexual abuse.

Metropolitan Police

170. Mahal has seven previous convictions since 2007 for thirteen offences. In 2010 he was convicted of sexually assaulting two females aged 15 and 19 years on public transport. He received a Community Order in 2011 for 3 years with probation support, 6 months curfew and was placed on the Sex Offenders register for 5 years. The Metropolitan Police Jigsaw team completed a referral to Newham Children's Services when Wafiya became pregnant.
171. Between 20 August 2012 and October 2014 there are detailed records of engagement between Newham Children Social Care social worker, the Metropolitan Police Jigsaw team and the family. In 2012 there were seven entries relating to pre-birth/birth of Wafiya's son and the risk posed by Mahal. A Child Protection Conference took place in October 2012 resulting in Imran being placed on a Child in Need Plan.
172. There were two occasions in February 2015 when Mahal attended Ilford Police Station to confess to sexual offences against children. These were investigated and unsubstantiated. The police completed a vulnerable adult report but did not share it as Wafiya said he was waiting for a mental health assessment.
173. The May 2019, October 2020 and January 2022 incidents at Mahal's mother's address were described as 'non crime domestic incidents' between him and his brother Hamza. In the October 2020 incident it was reported that Mahal had possession of a knife and had threatened to kill his brother. He was arrested but no action taken as his mother informed the police that the incident had not happened. A MARAC referral was not completed as the incidents collectively did not meet the threshold.
174. On the 10th May 2022, the police were called to the family home by neighbours who heard arguing. Both the parents were present, and the children were at school. They explained to the police that the argument was about financial issues. The police made a referral to Newham Children's Social Care on 12th May.

Department of Work and Pensions

175. Between May 2015 and February 2022 Wafiya was in receipt of a carers allowance from Department of Work and Pensions as Mahal's carer. In June 2015 Mahal made an application for a Personal Independence Payment (PIP)¹⁶ as he had

¹⁶ Personal Independence Payment (PIP) can help with extra living costs if you have both: a long-term physical or mental health condition or disability

suffered from depression since 2013. It is not clear whether professionals providing support services were aware of her additional responsibilities. Wafiya was helping to administer Mahal's prescribed medication.

North East London ICB

176. Mahal was seen by the GP in November 2020. He was reducing his medication. It was noted that his drug compliance was good and his mood stable. The family were moving to Stratford, and he was due to return to the family home. As part of the process of reducing his medication the GP had three telephone consultations with Mahal, December 2020, February 2021 and April 2021. The Covid pandemic reduced the opportunities for face to face appointments. In August 2021 Mahal appeared stable and was aware of the crisis plan and what to do if the symptoms returned.

Newham Children Social Care

177. In January 2019 the family were living in Newham. Mahal was living outside the marital home following a risk assessment for the children. Wafiya approached Newham Children's Services to enquire whether Mahal would be allowed to return home. In October 2019 the CIN Plan was closed after all the concerns were addressed except for permanent housing.

178. In March 2022 Newham Children's Social Care received a referral from the Doctor Care Anywhere GP service raising concerns about Mahal's mental health. The online GP services completed a referral to The Multi-Agency Safeguarding Hub (MASH). The manager of the MASH identified required actions that included a health check by the MASH Health Safeguarding Advisors. The allocated social worker visited the family on 15 March 2022 and concluded that both Wafiya and Mahal appeared to minimise concerns pertaining to Mahal's mental health. During a home visit on 14 April 2022, the children stated they were happy at home and at school. It isn't clear whether Mahal was present during the visit.

179. On 13 May 2022 the Allocated Social Worker called Wafiya following a report of them arguing on 10 May. Wafiya explained that she had argued with Mahal about finances, which had been resolved. Wafiya was offered domestic abuse support which she declined. A DASH risk assessment completed.

180. On 16 May 2022 the Allocated Social worker completed an assessment. Both parents were observed responding appropriately to the children and was observed being affectionate towards the children. The assessment recognised the risks of substance abuse, mental health and sexual convictions of Mahal however there is limited engagement from Mahal in the assessment. As such, his voice is minimal, and the assessment weighs more heavily on the children's presentation, other agencies views and mother's views. The assessment recommended that the case is closed to social care. On 19 May 2022 they received notification from the police of the murder of Wafiya by her husband.

East London Foundation Trust: (ELFT) Adult Mental Health Team

181. Mahal was known to the service from August 2016 to October 2020. Prior to this, he was receiving treatment in Redbridge. Between June 2017 and July 2018, as part of his discharge from East London Foundation Trust (ELFT) services, Mahal received mental health support by enhanced primary care liaison. Enhanced primary care liaison are a bridge service between ELFT secondary care and GP. The onus was on the GP to re refer if necessary. The GP was aware that they can either access the crisis line if needs an urgent referral and if less urgent can refer into community integrated mental health team.

182. On 16 June 2018, Mahal attended Newham Hospital complaining of depression asking for inpatient admission. The staff contacted Wafiya who confirmed he had stopped his medication. She had noticed a difference in his mood when he previously took it.

183. Mahal was referred and reviewed by psychiatric liaison team and reviewed by the duty doctor. He was discharged home with the following plan:

- Referral to Home Treatment Team (HTT)
- To attend HTT office follow day for assessment.
- HTT to consider restarting his anti-depressants.
- Given crisis team contact details.

184. As part of the discharge to Primary Care Mahal had a thorough mental health review 7 September 2020. He reported feeling stable and working as a civil servant. He reported he had no suicidal thoughts intentions or plans. His sleep, appetite and weight were fine. Mahal reported he did not smoke but did use Shisha¹⁷. Mahal presented with normal speech rate and tone, Euthymic, reactive mood and denied

¹⁷ Shisha – tobacco product smoked through a water pipe

any suicidal thoughts, intentions and denied any hallucinations delusions or illusions, with good insight. Mahal recognised the signs of when he's becoming unwell and would contact mental health services if this happened. He had crisis contact numbers.

London Borough Newham Homeless Prevention Service (HPAS)

185. In November 2017 Wafiya applied for emergency housing support after she was evicted from their home in Redbridge as she could not maintain the rent payments whilst living on her own. The family were provided emergency accommodation and recognised as a housing priority.

186. On 8 November 2017 Wafiya contacted Newham Homeless Prevention Advice Service notifying them that Mahal was no longer in the property. The tenancy was in Mahal's name. Wafiya was advised to make a new homeless application in her own name. A face to face meeting occurred on 8 November. Wafiya provided a copy of the deed poll for the change of her name and letters from Redbridge Children's Services confirming her husband wasn't allowed to stay with her. She was supported to change her benefit claim.

Bart Hospital

187. On 23 June 2018 Mahal was taken to Newham University Hospital by London Ambulance Service (LAS) after taking an overdose of venlafaxine, with suicidal intent. Mahal reported feeling low as he was unable to live in the same house as his wife and children. He was reviewed by the psychiatric liaison team on the Ward. It was agreed that an informal inpatient admission to Newham Centre for Mental Health would take place once he was medically fit.

Doctor Care Anywhere

188. On 3 March 2022 a Doctor Care Anywhere GP saw Mahal He reported having intermittent severe headaches and body numbness. He was concerned his food had been contaminated and he was being drugged. He did not feel that his wife was trying to harm him but thought he was going to die. He had no thoughts of self-harm or wanting to harm others. He denied any auditory or visual hallucinations. He was not on any medication at the time. He declined the opportunity to be assessed, and no referral was made to psychiatry. The private GP did not have access to his medical records. They had concerns about Mahal's mental health and made a referral to MASH the following day.

Information obtained during criminal investigation

189. As part of the murder investigation the police obtained witness statements from Wafiya's friends and family. Wafiya had shared some of her difficulties with Mahal's mental health and the financial constraints with her friends because he wasn't helping with money. The friends described Mahal as controlling. On one occasion Mahal came to collect Wafiya from work. They argued and he drove off with the children, leaving her waiting for 45 minutes. When he returned, he said, "let that be a lesson to you".

Witness statement Friend 1

190. Friend 1 explained that she met Wafiya due to their children attending the same school. They gradually became friends and would meet for coffee with another friend. After a while Wafiya disclosed information about her relationship with Mahal. She informed Friend 1 that Mahal's family were not happy that she had converted from Hindu to Islam.

191. She mentioned Mahal's mental health problems and suicide attempts which started when the children were small. Wafiya recounted her understanding of what had been explained to her by the social worker as being she needed to move Mahal out of the home otherwise she risked her children being taken into care. They helped each other by collecting the children after school. She knew Wafiya was struggling financially and would feed her children Farah and Imran and sometimes Wafiya.

192. Whilst caring for the children Imran told her that their house was cold at night and he couldn't get warm. Farah described their father as 'mean, selfish and heartless'. They both said that their parents argued a lot. Farah complained that she didn't have a bed which was giving her backache. She felt it wasn't fair as her brother had a bed. She felt scared when her parents argued.

193. Wafiya was often crying because Mahal would not help her financially. Wafiya said he was very controlling. On one occasion they argued about Mahal texting an ex-partner. Wafiya said he pushed her and hurt her back. When they lived in Stratford Mahal would disappear for days leaving Wafiya with the children. Once she tracked his phone and located it in Amsterdam. Wafiya seemed to change when they moved to Canning Town and became very depressed and worn down. She was physically and emotionally tired.

194. Friend 1 explained that she saw Mahal on many occasions when he came to collect the children. Mahal didn't speak and would avoid eye contact. Mahal told Wafiya to send the children to my house if she worked on Saturday's so he wouldn't

have to look after them. If they went out for food Mahal would make Wafiya pay. Shortly before the murder Mahal had taken the car away and was threatening to sell it.

195. Friend 1 had a WhatsApp conversation with Wafiya the day before her death about collecting the children. Two weeks later she spoke to Bahija via social media who told her that Mahal had murdered Wafiya. It was a total shock, and she couldn't take it in. She described Wafiya as a 'lovely person, patient gentle and caring'.

Witness statement Friend 2

196. Between March 2021 and March 2022, she worked in Dagenham, where she met Wafiya. They soon became friends and worked together a few days a week. Wafiya told her about her difficult marriage. She said they would fight a lot. Mahal would disappear for days and weeks without any contact. He was very jealous and made Wafiya activate her tracker on her mobile phone.

197. She tried to get Mahal help from his family, but they weren't interested. She said she wasn't close to her family because they weren't happy with the relationship. Two weeks before the murder Wafiya was crying a lot at work and talking to Mahal. He checked that she was at work and on one occasion went into the staff room, where the public are not permitted.

198. Wafiya told her that Mahal didn't contribute to the family financially she was struggling to buy things and would often abstain from eating to have food for the children. She desperately wanted Mahal to be back to the way he was when they first met. In the last few weeks, she said she had had enough and talked about leaving him. Wafiya mentioned many times that Mahal was acting crazy and that she didn't recognise him anymore.

199. Approximately two weeks before the murder Wafiya came to work with a black eye. She asked her if Mahal had caused it. She said, no but avoided eye contact and tried to change the subject. She said that she had done it herself on a door at home the day before. She didn't usually wear makeup but had a lot of foundation on trying to cover the bruise.

200. Friend 2 described Wafiya as having a warm heart and always kind to the customers. Wafiya would sometimes buy her a sweet treat at break times. She spoke about her children a lot; they were everything to her.

201. Four or five days before the murder Wafiya was crying at work. She gave her a hug. Wafiya explained that things with her husband were bad and she wanted to

leave him as she had had enough and didn't believe his promises. Friend 2 was very upset hearing of her friend's death.

Witness statement Friend 3

202. She became very good friends with Wafiya as their children went to the same school. She explained that it took Wafiya a while to open up to her about her problems with her partner Mahal. She would often be unhappy and upset.
203. She described how she quickly learned that Mahal was extremely controlling, especially with money. He would save his own wages and not give her much money towards the bills, petrol and shopping. Wafiya expressed on many occasions that she had no choice but to find a job and she still struggled to pay for heating, water and food. Mahal would take the car forcing Wafiya and the children to get up early and take the bus to school.
204. On one occasion after dropping off the children she was in her car with Wafiya when she received a call from Mahal. She listened to the call on speaker phone as Mahal blamed Wafiya for him leaving his lunch behind at home. He was aggressive and controlling. He kept calling her all day until she gave in and went home to collect the lunch and take it to him at work in Hackney.
205. She stated that early in 2021 she visited their home in Canning Town and witnessed Wafiya's daughter having to sleep on a thin cot bed on the floor because Mahal had not bought her a bed yet. Her daughter would complain about her back when she picked her up from school.
206. In November 2021 Wafiya informed her that she had argued with Mahal as he had used the hot water, but wouldn't let the children, or contribute to the cost. In December 2021 Wafiya was very upset after Mahal had come to collect her from work and after seeing her in the carpark drove off with the children. The children were really upset and her daughter persuaded him to go back to collect her. He told her he had done it to teach her a lesson.
207. She explained how she was always concerned about Wafiya and had suggested she leave Mahal and move to her fathers in Wembley. Wafiya always appeared worried and depressed. She said Mahal had a property in Pakistan and had spent £35,000 on it. She had witnessed bruising on Wafiya's face but didn't know where they came from.

208. In February 2022 she fell out with Wafiya as she was concerned about Mahal's treatment of her and the children and threatened to report it to social services. Wafiya started crying saying how much she loved him. She ceased contact with Wafiya, so she wasn't forced into making the call to social services. She described Wafiya as a very caring and gentle person, she seemed very much under Mahal's control. She was an exceptionally good mum to her children.
209. Wafiya's mobile phone was examined during the investigation. There were recordings where Mahal had locked her in a room and refused to let her out. There was photographic evidence of injuries to her face from February, April and May 2022. There was a note to her family dated 9 January 2022, informing them that she was leaving Mahal.
210. Ten days before she was murdered Wafiya messaged a friend. She explained that Mahal had accused her of cheating and grabbed her hair, scratched her face and *"this time"* caused a bump to her eye. She stated she had, *"not healed from the black eye"* he had previously given her. She told the friend to, *"tell my story to someone" who "might help or just listen"*. She believed that if the children had not been present, he would have killed her.
211. Other phone messages were found where she told friends that she didn't want to call the police but didn't feel safe and just wanted Mahal out of the home. She told the friends to look after her children if anything should happen to her. Wafiya can be heard accusing Mahal of hitting her and wanting to leave the house stating, *"the next time you will kill me, the next time you will kill me, I don't want that"*.

Overview

212. Wafiya supported her husband during his fluctuating mental health issues. She was cognisant of Mahal's criminal background but remained confident that Mahal would not harm the children. She continued to support Mahal even though he provided no financial support to the family. The financial challenges required Wafiya to work to support the family.
213. Wafiya had disclosed to friends, incidents of domestic violence and coercive control by Mahal. In the weeks before the murder she became increasingly concerned that he might harm her and talked about leaving him. The friends were torn between maintaining their support and loyalty to Wafiya and reported concerns to authorities. They have voiced their regrets in not having done so sooner.
214. Mahal had a history of mental health problems, which began before he married Wafiya and had children. He had episodes of deterioration in his mental health and

improvement following the birth of the children. The professionals involved with the family have evidenced the limited engagement he had with his children whilst they were on the Child Protection Plan and Child In Need plan.

215. Between 2015 and 2016 there were 3 occasions when Mahal was taken to hospital because of concerns for his mental wellbeing. Referrals to Children's Services and mental health support services were not completed on each occasion. There's no escalation or review of the mental health services provided to Mahal. He was detained under Section 136 Mental Health Act on each occasion following an overdose of his prescribed medication. He was assessed and diagnosed with Recurrent depressive disorder.
216. The conviction for sexual offences against children was a key element of risk for Redbridge Children's Services and Newham Children Social Care during their engagement with the family. Mahal's offending history, mental health instability led to an attempted overdose in January 2016. This raised concerns about the impact on the children and the risk he caused to them emotionally. It was these concerns that led to the S47 assessment and Mahal being asked to leave the home. At the conclusion of the Newham Child in Need plan Mahal was allowed to return to the family home having spent two years living with his mother and brother.
217. During his time with his mother, Mahal was involved in two non-crime domestic incidents and one reported crime where his brother alleged that he had threatened him with a knife. The allegations were not substantiated. As there were no children at the property the incidents were not shared with other professionals. The DASH risk assessment did not meet the criteria for MARAC. It could have been considered based on the officer's professional judgement.
218. The Children In Need Plan was closed in October 2019 after a number of meetings with the family and professionals, with the task of allocating permanent housing outstanding. Wafiya asked Redbridge Children Services if Mahal could return to the family home. A pre-return risk assessment was completed in accordance with their procedure. In September 2020 Mahal was subject of a mental health review by his GP. He was feeling stable and was working as a civil servant.
219. Following three consultations with the GP December 2020, February 21 and April 21 he stopped taking his prescribed anti-psychotics and anti-depressants medication. He should have had a consultation appointment three weeks after stopping his prescribed medication. The appointment did not take place until two months after he stopped the medication.

220. In March 2022 Mahal contacted Dr Care Anywhere online service with intermittent headaches and reported concerns that the government was drugging his food. The GP Safeguarding lead was spoken to and a MASH referral completed. The sudden decline in his mental health did not trigger an assessment on the risk to Wafiya and the children and he was not referred for psychiatric help. This was highlighted as a lesson learnt during the Rapid Review. (Appendix A)

221. The full history of the domestic abuse, violence and coercion was not apparent until after Wafiya's murder. The information from her work friends evidenced how they supported Wafiya, looking after the children and feeding them. They witnessed Mahal's abusive and controlling behaviour. Four or five days prior to the fatal incident Wafiya disclosed to Friend 2 her intention to leave Mahal as she was concerned about his behaviour and didn't believe his promises to her. In May 2022 Mahal murdered Wafiya in front of the children.

Analysis

222. Each term appears in bold and is examined separately. The analysis explores the elements of the ToR considered by the panel for commentary using the material accumulated during the review and Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

Could improvement in any of the following have led to a different outcome for Wafiya, considering:

- a) **Communication and information sharing between services with regard to the safeguarding of adults and children**
- b) **Communication within services**
- c) **Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services**

223. There is good evidence of communication and information sharing between Children's Services in Newham and Redbridge whilst the children were the subject of protection plans. The information provided by the social worker during visits highlighted the close relationship Wafiya had with her children. The social worker witnessed Mahal's difficulty in talking and engaging with professionals.

224. During the family assessments the social worker displayed professional curiosity of the families lived experiences engaging with the children to establish their views. Wafiya was cognisant of her husband's mental health needs and how to reach out for services if required. Mahal was not asked the same question. This was

highlighted by the author of the Newham Children's Social Care IMR as an expected action considering Mahal's history of mental health issues. A referral to Adult Social Care could have also been considered as part of the assessment.

225. It also highlights how those involved in providing services to children subject to care are more likely to engage with the mother rather than the father to establish information and the family narrative based on gender-based stereotypes¹⁸ There were a number of visits by Newham and Redbridge Children's Services where Mahal was not available due to personal reasons. On one occasion he was praying. There's no indication that arrangements were made to revisit when he would be available to engage in the meeting.
226. In January 2019 Wafiya contacted Newham Children's Social Care enquiring whether Mahal could return to the family home. An interagency MASH referral was completed the same month. In February 2019 Wafiya and her daughter discussed the request with the health visitor. Wafiya stated that Mahal was asked to leave the family home because he had depression. The health visitor contacted the social worker requesting further information. The review has not established whether the information was provided and if it featured in any future decision making.
227. A risk assessment for the children was completed before the conclusion of the Child In Need Plan in October 2019 with an outstanding action to identify permanent housing for the family. It is not clear whether the assessment took into consideration Mahal's attempted overdose in October 2018 and the incident with his brother, where he allegedly threatened him with a knife in May 2019. Mahal was permitted to return to the family home following a risk assessment. As the CIN Plan had concluded there may have been an absence of legislation to support any further intervention.
228. There were three reported incidents involving Mahal and his brother recorded by the Metropolitan Police. The escalation in the threats between Mahal and his brother led to his arrest after the second incident in October 2020. The Metropolitan Police were aware of Mahal's historic criminal background and mental health incidents. The incidents were assessed as standard risk. The escalating incidents, threats of weapons and previous violent history are criteria for a referral to MARAC.

¹⁸ Gender stereotypes are defined as preconceived, usually generalized views about how members of a certain gender do or should behave, or which traits they do or should have. These stereotypes can perpetuate inequalities and be harmful through limiting someone's ability to develop personal skills, pursue professional careers or even make individual choices about their lives.

229. Hina denied there had been any incidents involving a knife between her sons. The panel has not established her reason for this. It could be to protect her family and/or her community standing. These are considerations that cannot be determined without further information from the family.
230. The information regarding the threats and alleged use of weapons was not shared with children services as there were no children present. The threats of violence and weapons could have impacted on future assessments and interactions with the family. A referral to MASH for Newham Children's Social Care and Adult Social Care should have been considered. The question of the dissemination of information pertaining to risk from adults posing a risk to children was highlighted as a lesson learnt during the Newham Safeguarding Children Partnership Rapid Review.
231. Wafiya regularly spoke to professionals on Mahal's behalf during visits. She displayed a united family relationship during her engagements with service providers. There was a general acceptance of what she said at face value without discussion with Mahal. This is evidenced during the social worker visits. Speaking to Mahal more frequently could have provided information or identified inconsistencies in Wafiya's account, highlighting domestic abuse and controlling behaviour.
232. Mahal had been on prescribed medication Venlafaxine (antidepressant) and Olanzapine (mood stabiliser also used as an antipsychotic) These were prescribed in Redbridge prior to 2015. The Adult Mental Health team were instrumental in the decision to withdraw him from the medication in November 2019. It is not clear whether this decision was shared with Primary Care or other professionals. He was completely weaned off anti-psychotics and anti-depressants by April 2021. During his last visit with his GP in August 2021, he appeared stable and no concerns regarding his mental health were noted. Mahal had a crisis plan and knew who to contact if his mental health deteriorated.
233. In March 2022 Mahal contacted 'Dr Care Anywhere' online private GP service with headaches and delusion thoughts that the Government was drugging his food. There were elements of good practice by considering the risk to the wider family. A MASH referral was completed. The private GP did not have access to Mahal's medical records and was not able to recognise the significant deterioration in his mental health or the potential impact on the family. The expected practice would be to seek psychiatric support for Mahal. This did not take place which was an opportunity missed.

234. Redbridge Children's Services Safe and Together Domestic Abuse model has been in place since 2022 and continues to be delivered to new starters and the principles of the model embedded in practice. Reach Out Domestic Abuse Service went live as the front door for DA referrals, risk assessment, safety planning and intervention work for the whole of Redbridge in September 2023. They work in partnership with other independent gender-based violence advocates (IGVA) services in Redbridge to ensure victim/survivors have access to support which considers ethnicity, sexuality, level of risk and where the survivor is in their journey.

Whether the work undertaken by services in this case are consistent with each organisations:

a) Professional standards

b) Domestic abuse policy, procedures and protocols

235. In 2015 the Metropolitan Police responded to two incidents where Mahal attended Ilford Police Station claiming to have committed sexual offences. He was taken to King George's Hospital for mental health assessment. The police completed a vulnerable adult report on each occasion but did not share the information with Mental Health Services as they were aware and avoided duplication. This could influence future mental health assessments.

236. Wafiya's murder initiated the Rapid Review in June, July 2022. The agencies involved have highlighted lessons learnt and missed opportunities within their own organisations. These feature in the Rapid Review action plan (Appendix A). The deadline for the completion of the actions has passed whilst the DARDR has been ongoing. Some of the learning has also been highlighted during the DARDR and features in the individual lessons learnt.

237. After the domestic incident on 10 May 2022, the allocated social worker carried out a single agency assessment. Wafiya described it as a minor argument about finances. She was signposted to domestic abuse services. The case notes indicate that Mahal was not spoken to as part of the assessment. This was an opportunity for professional curiosity to establish any potential concerns regarding domestic abuse. The author of the Newham Children Social Care IMR has highlighted this as a lesson learnt.

238. Weeks before her death, Wafiya had confided in friends about her financial difficulties. She was the victim of domestic abuse, which she disclosed to friends but not with her family. She voiced her love for Mahal to one of her friends and her unwillingness to get him into trouble by reporting the abuse. Her phone messages

indicated her growing concerns for her safety asking a friend to look after the children if anything happened to her.

239. Wafiya's death had a traumatic impact on her family and friends. Her friends at work did not feel able to share their concerns about the children and her domestic abuse without losing her trust and confidence. It is not known whether there were avenues for anonymous disclosure of concerns regarding domestic abuse in their respective work places. This is an aspect the panel supports further consideration outside of the DARDR review.

240. There were a number of professionals who supported the family. The panel members have reflected on their own avenues for disclosing concerns about domestic abuse within their professions and have taken this opportunity to recommend a review of their domestic policies and support for staff to provide opportunities where disclosure can be made anonymously and sign post staff to internal and external domestic abuse services.

241. **The response of the relevant agencies to any referrals from January 2015 relating to Wafiya and Mahal. It will seek to understand what decisions were taken and what actions were or were not 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 with Wafiya and Mahal.**
- 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 any risk assessments undertaken by each agency in respect of Wafiya and Mahal.**

242. Throughout Mahal's time as a registered sex offender his children were subject to regular risk assessments and reviews considering their safety and emotional impact of behaviour in the family home. The concerns whether the children were at risk of sexual abuse by their father narrowed the vision of the agencies to consider links to domestic abuse and coercive control.

243. Between June 2015 and March 2019 Wafiya was receiving financial support through the Department of Work and Pensions (DWP) as a carer for Mahal and the

children. Her sister and friends provided emotional support. It is not clear whether professionals were aware of Wafiya's financial constraints and how this was affecting the family. In July 2015 Bahija suggested to the social worker that her sister would benefit from support to preserve the family unit. Wafiya could have been offered a carer's assessment to see if she qualified for additional assistance. This was not considered by professionals. The national eligibility threshold for carers sets out who can be eligible for support¹⁹

244. In November 2017 Wafiya and the children were evicted from their accommodation in Ilford. They were provided emergency accommodation by Newham Housing. It is not clear whether the circumstances or the eviction was shared with other agencies. This must have been challenging time for Wafiya as she was living on her own and struggling financially. There's little indication that the emotional effect on Wafiya as a mother and carer was considered or evidenced.

245. In June 2018 Mahal took an overdose of his anti-depressant medication. He was taken by ambulance to hospital. Wafiya provided the background information as Mahal was selectively mute. He told the psychiatric liaison team that he was low because he was not living at home with the family, even though he saw them most days. The emergency department staff were aware of Mahal's previous sexual offences and this being his third attempted overdose. There's no evidence within the records that a referral was made to Children's Social Care, or they were otherwise notified.

246. On 7 September 2019 the GP completed a mental health review. Mahal was considered 'stable'. In December 2019 he was seen in the Outpatient Clinic, Community Recovery Team, by their psychiatry staff. It was agreed that he would reduce his anti-depressants and psychotic medication. There were regular reviews and reductions in the medication. In April 2021 Mahal was no longer taking the medication. The panel has not established who was involved in the decision making process and whether Wafiya or Children's Social Care were informed.

Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

247. There is a good level of intervention whilst Mahal was on the sex offender's register. The family received announced and unannounced visits on a regular basis. Due to Mahal's overdose and behaviour during visits in January 2016 there were concerns that Mahal could be a risk to the children. Newham Children's Social Care

¹⁹ The National Eligibility Criteria is set out in section 13 of the Care Act. Whenever a document or person refers to section 13 of the Care Act they are referring to the National Eligibility Criteria, even if they do not specifically use that phrase.

initiated a Section 47 investigation to consider whether the children should be taken into care. Although this was a difficult time for Wafiya, the decision was appropriate given the circumstances.

248. Wafiya was worried about her ability to pay the rent whilst Mahal was not allowed to be in the family home. She was concerned she would be made to move home. She was also concerned about the outcome of the independent social worker report, which classed the children as being at risk due to neglect. The joint visit between social workers did not take place. This could have provided enhanced support for Wafiya and helped to reduce her growing concerns.

249. The online private GP service made a MASH referral in March 2022, which was managed and reviewed by the MASH Manager. The manager identified actions that included a health check by the MASH Health Safeguarding Advisors. The health check is to provide information on all household members, including parents, which may potentially be held by Community Child Health; Child and Adult Mental Health; GPs; Acute Hospital services, including A&E and Outpatient clinics. According to the Rapid Review these actions were not completed.

250. Following notification from the MASH Newham Children Social Care took immediate action completing an assessment with direct engagement with the children. The unknown information could have provided a wider review of the family's position and Mahal's mental health requirements. The review cannot weight the significance of this opportunity and whether it would have had any impact on the overall outcome.

Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

251. Wafiya made the decision to convert to Islam so she could marry Mahal. She told her sister that they wanted to be married before they had children. The decision affected their relationship with their respective families. Muslim men are permitted to marry non-Muslim women as long as they are 'people of the book'.²⁰ If they are not the woman is expected to convert.

252. Interracial relationships bring about a heightened risk of racial micro aggressions, discrimination or social stigma. According to a 2021 report by dating

²⁰ Christians and Jews

app Inner Circle mixed couples are most likely to suffer negative reactions from friends, family and colleagues.²¹

253. Throughout the engagements with Wafiya and Mahal professionals have not been able to establish the views of their wider families. Wafiya's sister has willingly engaged with services to provide background information and support for the family. She was aware of the unhappiness between the families following their quick marriage and Wafiya's change of religion. There's no indication that Mahal's decision to murder his wife was religiously motivated.

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

254. There are good management and oversight for the care of the children whilst they were subject to the child protection plan and child in need plan. These were subject to regular reviews and the sharing between the professionals. In April 2014 the Redbridge Manager reviewed and closed the child protection case having been satisfied that the risk to the children was minimised.

Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services

255. The Newham Safeguarding Children Partnership Rapid Review identified lessons to be learnt, which were collated into an action plan with named leads from organisations. Many of the actions on the plan have been completed before the DHR process resumed in May 2023.

256. The organisations providing support to Wafiya and the family have not identified or witnessed any signs of the control Mahal had over Wafiya. There were many occasions when Mahal was absent from the engagements with professional or had minimal involvement. There were opportunities to include Mahal and not just accept the account provided by Wafiya.

257. Wafiya's friends had witnessed Mahal's abusive and controlling behaviour. Reducing her access to the car and withholding financial support for the children. It is disappointing that there's no indication that any signs of Mahal's control were identified or referenced by those services regularly providing support to the family. There is an opportunity to refresh practitioners' knowledge around coercive control.

²¹ <https://pih.org.uk/front-page/mixed-up-in-love/>

258. A review of recent DARDR's in Newham has highlighted reoccurring lessons.
- Taking a whole family approach lens to understanding DA by speaking to everyone within the home/family
 - Agencies should always use the DASH RA where there are disclosure/ concerns of DA to ensure that agencies are asking the right questions and considering the varying risk factors
 - Agencies should consider referring cases to MARAC based on professional judgement
 - consideration needs to be applied to referring to MARAC when DA perpetrators are using weapons to threaten others

Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

259. Bahija has requested to receive a copy of the completed review. She will be provided an opportunity to read the report and add any additional information or comments.

Conclusion

260. Throughout the review the safety of the children remained the focus of the agencies involved with the family. The superficial compliance by the parents was recognised but accepted on face value with opportunities missed to establish the holistic picture from both parents during engagements. The financial concerns could have influenced Wafiya's decision to allow Mahal to return to the family home, along with ensuring the children could see their father.
261. The full picture of Wafiya's abusive and controlling relationship by Mahal only became known following the murder investigation. The details of her concerns about how he treated her and the potential risk to her safety were only identified from the information on her phone. Wafiya displayed a positive and supportive relationship with her husband during engagements with professionals. Mahal maintained his control by minimising her financial capacity and use of the car. According to Refuge, these are identified signs of coercive control²² Wafiya had disclosed elements of the abuse to her friends, meaning important insights were known to those close to her but were not known by agencies.
262. Wafiya received carer allowance from DWP between 2015 and 2019 as Mahal's carer. There are many options for emotional support for carers in Newham, including support groups, workshops, and advice services. They are predominantly in place

²² Refuge - What is coercive control?

for those not in receipt of financial support. There's no indication that Wafiya was signposted to organisations, such as Newham Carers Community for emotional support whilst dealing with Mahal's mental health frailties.

263. In January 2022 Mahal had stopped taking his depression and anti-psychotic medication. The review has not established what triggered his crisis call to the private GP service seeking mental health support. The triage service was undertaken without access to Mahal's medical records. There was an opportunity to refer him for psychiatric treatment which was missed.

264. The review has reflected on Mahal's history of mental health concerns and related incidents, which are a significant contributory factor in his background and relationship with Wafiya. The review acknowledges the post incident psychiatric report prepared to assist with sentencing which highlighted Mahal's risk was not driven by a psychotic mental state but anti-social personality with an ingrained propensity for violence. There was no evidence of a severe and enduring mental illness.

265. The domestic incident on 10 May 2022, nine days before Wafiya's death gave no indication of the violent attack she would suffer at the hands of her husband. The family and friends have reflected on their relationships with Wafiya and their opportunities to share their concerns with professionals.

Lessons learnt

266. The lessons learnt have been taken directly from agencies IMRs. There are a number of agencies that have not identified any learning from the review. The Newham Safeguarding Rapid Review Lessons learnt can be found in Appendix?

Newham Children Social Care

267. We acknowledge that fathers play a significant role in children's lives and can exert a substantial influence on those they care for. However, in practice, they are sometimes overlooked by professionals who tend to focus primarily on the care provided by mothers or female caregivers. This review underscores a notable gap. The incident involving Wafiya and Mahal, which prompted a Police intervention, was only discussed with Wafiya, and her account was the sole source of information. There is no indication that this incident was also explored with Mahal. Practitioners often rely too heavily on mothers to provide insight into family dynamics and narratives, a practice that can inadvertently lead to crucial information being missed or inconsistencies in the mother's account going unnoticed. Exploring this Police Merlin with Mahal could have potentially revealed further concerns about his mental

health and/or domestic abuse concerns. The reviewer recognizes that a heavy caseload can impede professional curiosity. In hindsight, it becomes evident that information should be scrutinized rather than accepted at face value. It is imperative to maintain an open mind regarding service user accounts and seek additional information when necessary.

Domestic Abuse

268. After receiving the Police Merlin report dated 10.5.2022 (received on 12.5.2022), which detailed a verbal argument, the Allocated Social Worker initially discussed this matter with Wafiya, who described it as a 'minor argument.' It is commendable that case records show that domestic abuse was explored with Wafiya, and support services were recommended. However, the reviewer believes that the Allocated Social Worker could have shown greater professional curiosity. Professional curiosity entails "looking past the obvious" and involves a combination of observation, active listening, direct questioning, verification, and reflection on information received. It means not relying solely on a single source of information and testing professional assumptions. Effective professional curiosity includes cross-referencing information from various sources to gain a comprehensive understanding of family dynamics and the experiences of the child/children. This helps in making predictions about future events. A 'minor argument' would not typically lead neighbours to call for Police assistance. This could have been an opportune moment to uncover potential concerns related to domestic abuse. There is a need for all frontline professionals to confidently explore domestic abuse with victims/survivors, even in cases of denial or minimization, and to understand and address the barriers to addressing domestic abuse beyond surface-level inquiries.
269. The reviewer is concerned that the Police Merlin report was received before the assessment was completed but was not included, referenced, or considered as part of the assessment. Police notifications are valuable, and while a crime might not have been reported, such information can provide a broader perspective and a deeper understanding of the family's experiences.
270. The reviewer refers to a case note dated 19.5.2022 recorded by the Allocated Social Worker after Wafiya's murder. In this note, the Allocated Social Worker records the following 'On our way to foster carers house, Farah asked whether SW remembers when she said she told mummy to leave dad. SW said 'yes'. Farah asked do you know why I said that SW said, no; She then said because he was arguing with mummy'. This conversation had not been documented in any prior visit episode before Wafiya's tragic death. This is a significant oversight. Farah's statement that her mother should leave her father could have been indicative of domestic abuse

concerns and should not have been overlooked or discounted until adequately assessed.

271. The reviewer is also minded that during the assessment process, Farah and Aayan were not seen outside of the home, such as at school, in a neutral environment. Best practice recommends that a child's social worker should occasionally meet the child outside the family home, as this can strengthen the professional relationship and create a more conducive environment for the child to discuss concerns, in the interests of child protection. This was not a child protection case, and the social worker did not have any evidence to suggest that the children were at risk of significant harm. It is important to acknowledge that not in every case the social worker would be able to see children outside of the family home unless there are significant concerns. In any case consent would also be required.
272. Additionally, there is no evidence of various age-appropriate tools being used for direct engagement and exploration of the children's world and experiences. The use of such tools could have been valuable in identifying risks, themes, and protective factors that might have been missed in verbal conversations.
273. Furthermore, involving extended family in the assessment and planning process is of great importance. The assessment mentions that the family has extended family members, both maternal and paternal, with whom they maintain regular contact. However, the views of the extended family network were not sought throughout the assessment and planning stages. Hearing from these family members and exploring the nature of their support could have been instrumental in enhancing safety measures and planning for the family. This consideration should also extend to exploring Family Group Conferences early in interventions with families, particularly in light of the subsequent viability assessment in respect of maternal aunt, Bahija. Within the viability assessment following Mahal's murder, Bahija is reported to have shared with the assessing Social Worker Bahija informed me that a week ago her sister told her that she informed her husband that she is going to leave him if he does not change'. This is another indication of possible domestic abuse. This information could have been uncovered in the s.17 assessment process if significant extended family members had been consulted with. It would have connected more 'dots' (Farah telling Allocated Social Worker that her mother should leave her father and Police Merlin 10.5.2022) and pointed to a more comprehensive understanding of the relationship between Wafiya and Mahal, a relationship characterized by domestic abuse. This may have uncovered concerns about the risk faced by Wafiya and the environment to which the children were exposed. However, exploration with extended family members would have required the consent of parents which may have not been provided.

274. It is also important to acknowledge that social workers would not routinely speak with all extended family members unless the family member has a relationship and are in contact with the children. In this case Wafiya said she had limited / or no contact with her family members.

Mahal's mental health

275. Was there any indication that Mahal posed a potential risk to Wafiya or his children in terms of his mental health? Research suggests that when an individual does not exhibit overt signs of a significant mental health problem affecting their presentation, the assessed risk is likely to be low. It is difficult to determine criminal intent in these circumstances if it is not expressed through conversation or behaviour. The assessment and case records show that both Mahal and Wafiya denied any deterioration in Mahal's mental health. The Allocated Social Worker demonstrated curiosity in exploring Wafiya's understanding of Mahal's needs and her ability to recognize signs of his mental health deteriorating and the actions to take in such an event, which she described clearly. However, it does not appear that the Allocated Social Worker asked Mahal the same questions, such as how he would recognize a deterioration in his mental health and what actions he would take. The assessment simply records 'Wafiya report that he knows the triggers' without further exploration or clarification.

276. In the context of Mahal's contact with the online GP, where he reported concerns about being poisoned and government involvement, Mahal denied this reporting, explaining it as a misunderstanding. Given Mahal's mental health history, it is unlikely that this was a misunderstanding. Considering Mahal's longstanding mental health issues and the seriousness of the recent referral, one would expect that Mahal's GP would have been consulted. The question arises as to whether there was an over-optimistic outlook on the situation. This prompts us to reflect on what leads agencies or practitioners and their supervisors, to be overly optimistic, and what factors might have counteracted this optimism.

277. The reviewer acknowledges the possibility of hindsight bias in identifying gaps and is aware that the decisions made at the time were based on the context and information available then.

Redbridge Children's Services

278. The importance of understanding links between sexual abuse/offending and domestic abuse, professional curiosity and being creative and tenacious in seeking victim/survivor's voices, both adult and children, to ensure effective risk assessment and safety planning.

North East London ICB

279. Antenatal referrals and routine questioning for domestic abuse have changed significantly since Wafiya accessed antenatal services in 2012 and 2013. Joined up working between primary care and health visitors has also improved in this time period.

Barts Health NHS Trust

280. The assessment of Mahal did not consider the “All Age Safeguarding”, therefore Emergency Department Staff (ED) are reminded that when conducting holistic assessment, they should consider inquiring about the children and wider family. In addition, ED staff should contact Children Social Care to confirm involvement/status of children. Confirmation of parent’s details when they attend with children, should form part of the holistic assessment.

Metropolitan Police SCRG

281. 31/05/2019 – Non crime domestic between Mahal and his brother:

282. Mahal was arguing with his mum, Hina, about living space as she continually walked into his bedroom. Mahal lived with his brother, Hamza at their mum’s address along with their spouses and children. Hamza stepped in to defend his mum in the argument when Mahal started arguing with him and it escalated to the point where Hamza called police. He told police that Mahal had picked up a knife and a disturbance could be heard in the background.

283. When police attended Hamza had already left the address and police spoke with Mahal who refused to answer the police Domestic Abuse, Stalking, Harassment and Honour based Violence Assessment (DASH) questions. Other family members were spoken to by police who said it was an argument between brothers, and no knife had been seen.

284. Police contacted Hamza by phone, and he said he had had enough of the arguments and would stay at his sisters for the night, no allegations were made and he did not wish to speak with police further.

Comments:

285. This incident was treated as a standard risk, and it is not clear if Wafiya and the children were permanently staying at Mahal’s mum’s address. During the incident on 18/01/2019 Wafiya was asking children services if Mahal could move back to the family home as he had been staying at his mum’s but in this report, it states the spouses and children were staying at the mum’s address.

286. No MERLIN reports were created for the children, this should be done as standard practice at domestic incidents and Mahal's previous background only highlights this need; however, it is unclear if the children were at the address during the incident.

287. MPS policy dated September 2021 states, "Complete MERLIN report in all domestic cases where children are included in the relationship, whether present or not and including unborn children" Due to this policy being agreed and implemented after the incident the review officer makes no further recommendation.

Identified Good Practice

Newham Children's Social Care

288. MASH contact in March 2022 provides evidence of good practice. Decision making at this time is clearly informed by a chronology of events. There is clear analysis of impact on the children and rationale from the MASH Social Worker to support their recommendation. Management oversight refers to presenting risk and history. Management oversight is thorough and of good quality. Decision to progress to s.17 assessment appears proportionate. This contact was progressed within timescales and there is evidence of feedback back to the referrer and family regarding case direction.

289. During assessment process, visit timescales appeared to be met. The aim of visits is consistently clear and evidence purposeful, planned and focused intervention. Children were seen alone as part of the assessment process. The assessment process engaged both Wafiya and Mahal and sought the views of both the children.

290. The assessment does well to assess both Imran and Farah's child development needs and how well these were being met. It is good practice that the Allocated Social Worker sought up to date information from the children's school and health. This evidences thoroughness and attempts to ensure the assessment is holistic. Information from Mahal's probation officer obtained from previous social care records was also used to inform assessment. This information refers to Mahal's historic mental health presentation which was of concern however Mahal was last involved with probation in 2013.

291. After receiving the Police Merlin report dated 10.5.2022 (received on 12.5.2022), which detailed a verbal argument, the Allocated Social Worker discussed this matter with Wafiya, who described it as a 'minor argument.' It is commendable that case

records show that domestic abuse was explored with Wafiya, and support services were recommended.

Redbridge Children's Services

292. While the approach was focused on the perpetrator's sex offending and mental health, the approach from children's services wasn't DV informed and clues were missed such as him stating he had slapped his wife when he was in an A&E department, along with DV being present in 65% of child protection cases. If a greater understanding of DV had been present, I feel the outcome could have been different. There was tenacity evidenced by the social workers involved although this lacked creativity.

North East London ICB

293. Her medical issues were dealt with quickly and suitably.

Barts Health NHS Trust

294. There was appropriate care delivery to both Wafiya, Mahal and the children. At all contacts, there were appropriate referrals to specialist health services such as Psychiatrist Team, Gynae team.

Recommendations

295. The recommendations have been developed with the panel. There is an expectation that they will be acted on through the development of an action plan. Single agency recommendations are included within the action plan with an identified named owner. Any recommendations which mirror those identified during the rapid review are identified with an asterix.

296. Many of the organisations have already identified and addressed the learning identified during the review. The recommendations are based on what was known at the time of their involvement with Wafiya.

297. Newham Community Safety Partnership should seek reassurances that the following recommendations will be addressed:

Recommendation 1

Newham Children's Social Care - In circumstances where a parent has been required to leave the home due to significant risk of harm to the children a pre-return assessment of risk and vulnerabilities to the children, including the financial wellbeing of the family, should be considered.

Recommendation 2

All front line practitioners charged with providing a service within the family where there are concerns regarding domestic abuse, care, risk and vulnerability should avoid gender stereotyping by engaging both parents/partners to establish the family narrative.

Recommendation 3

Wafiya was receiving financial support as Mahal's carer. Wafiya should have been subject to a carer's assessment in accordance with the Care Act 2014, to identify whether she could receive any additional emotional support.

Recommendation 4

The signs of coercive control were not recognised and acted upon. Professionals should identify ways to embed professional curiosity regarding coercive control and domestic abuse within their general day to day practices. This could include training on indicators of domestic abuse, improving relationships, trust and confidence with victim survivors. How to ask the question and how to respond and document safely – in all these areas with respect to domestic abuse.

Recommendation 5

The private GP provider (Dr Care Anywhere) should review its current practices in the sharing of information for patients who consult with high risk mental health concerns. Where risks are present local crisis mental health services and GP services should be notified as previous mental health history may not be known. Nationwide crisis services can be notified through 111 option 2 *

Recommendation 6

Guidance for referrals to MARAC following domestic abuse include threats of violence and weapons. All organisations with a responsibility for considering MARAC referrals should review their criteria and remind staff of the use of their 'professional judgement' to enhance their decision making.

Recommendation 7

Redbridge and Newham Children Services should review their use of written agreements to provide support to victims of abuse and not hold them accountable for the behaviour of the perpetrator or child protection concerns.

Glossary

DARDR	Domestic Abuse Related Death Review
GPMS	Government Protective Marking Scheme
DVPP	Domestic Violence Perpetrator Programme
HEMS	Helicopter Emergency Medical Service
TOR	Terms of Reference
IMR	Individual Management Review
NCSP	Newham Community Safety Partnership
CJSM	Criminal Justice System Mail
AAFDA	Advocacy After Fatal Domestic Abuse
LAS	London Ambulance Service
DWP	Department of Work and Pensions
MASH	Multi-Agency Safeguarding Hub
IOPC	Independent Office for Police Conduct
CPP	Child Protection Plan
MARAC	Multi-Agency Risk Assessment Conference
MAPPA	Multi-Agency Public Protection Arrangements
CIN	Child In Need
MHA	Mental Health Act
DASH	Domestic Abuse, stalking and 'honour'-based violence.
HTT	Home Treatment Team
CRHTT	Independent Gender-based Violence Advocates
ED	Emergency Department Staff
CPS	Crown Prosecution Service
SCRG	Serious Crime Review Group
IDVA	Independent Domestic Violence Advisor