Newham Safety Partnership

Domestic Abuse Related Death Review

Executive Summary

Name: Wafiya

Died May 2022

Chair and Author: Derrick Laing

October 2024

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Contents

	Page
Introduction	3
Author of the Review	4
Terms of Reference	5
Victim	6
Perpetrator	7
Summary of the chronologies	7
Key Issues arising from the Review	13
Conclusion	14
Lessons Learnt	15
Identified Good Practice	20
Recommendations	21

Introduction

1. This summary outlines the process taken by Newham Borough Council Community Safety Partnership in establishing a Domestic Abuse Related Death Review (DARDR), in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004. The review was independently chaired by Derrick Laing to examine agencies responses and support given to Wafiya (not her real name) at time of her death in May 2022.

2. 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.

3. 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.

4. 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.

5. 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	Son		Asian British Pakistani
Farah	Daughter		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

6. The review began with an initial meeting on 28 June 2022 of all the agencies that might have had contact with Wafiya, Mahal and their family prior to her death. 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. The agencies involved in the review are:

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

7. There was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. 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.

Author of the Review

8. Derrick Laing from Sancus Solutions was chosen as the DARDR Independent chair and Author. He is a practitioner employed by Sancus Solutions which is an intelligence and investigations training company in the UK, who are experienced in delivering domestic homicide reviews and were procured to undertake this DARDR.

9. He was proposed by the company as he has no knowledge of the case and no prior connections with the area or any of the agencies involved in the review. He was appointed as the independent Chair of the Panel and author of the Review in September 2022. An independence statement outlining his background can be found at Appendix C.

10. He is currently involved in a number of other Reviews in different geographical areas. He has completed the Home Office DARDR online training and attends events organised by Advocacy After Fatal Domestic Abuse (AAFDA) as part of his continual professional development.

Terms of Reference

11. 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

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

    a) Professional standards

    b) Domestic abuse policy, procedures and protocols

13. 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.

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

15. 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.

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

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

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

Victim

19. Wafiya changed her name and converted to Islam prior to marrying Mahal. She informed her family after she was married. They initially lived with Mahal's family until they moved to housing in Newham. Wafiya was the mother of two young children.

20. During their relationship Wafiya found out 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.

21. 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.

22. Wafiya made disclosures to her sister and work colleagues regarding her financial struggles and how Mahal did not support her and the children. She was struggling to support Mahal whose mental health had deteriorated and his behaviour towards her had worsened. 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.

23. 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.

Perpetrator

24. 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 Metropolitan Police Jigsaw Team in Newham.

25. Mahal was known to North East London Integrated Care Partnership since 2011. They provided joint health and care services in the NHS. His medical records indicate anxiety and a history of drug abuse. He attended hospitals and police stations seeking mental health support and making unsubstantiated confessions of sexual offences. On three occasions he was detained under Section 136 Mental Health Act.

26. Mahal agreed to be interviewed by the chair of the review. He was difficult to understand and whispered his responses. He outlined the medication he was prescribed for his mental health. He indicated that about a month before the murder he was made to stop taking his 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.

Summary of the chronologies

27. 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 prefaced 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

28. **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.

29. **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.

30. **RCS**. During a strategy meeting in March 2014, it was recognised that the family accommodation was unsuitable.

APRIL 2014

31. **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

32. **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

33. **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.

34. **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.

35. **RCS**. Wafiya signed a safeguarding agreement not to leave the children with Mahal due to his previous sexual offences.

MARCH 2015

36. **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

37. **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

38. **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

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

40. **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

41. **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

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

JANUARY 2016

43. **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 Team[1]

[1] 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).

44. **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.

45. **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

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

MAY 2016

47. **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

48. **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

49. **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

50. 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

51. **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.

52. 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

53. **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

54. **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

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

MAY 2019

56. **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

57. **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

58. **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

59. **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

60. **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

61. **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

62. **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

63. **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.
64. **NCS**. Received a referral from the Doctor Care Anywhere GP[2] service raising concerns about Mahal's mental health. The online GP services completed a referral to The Multi-Agency Safeguarding Hub (MASH).

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

66. **NCS**. On15 March 2022 the social worker visited the family and concluded that they appeared to minimise concerns pertaining to Mahal's mental health.

APRIL 2022

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

MAY 2022

68. **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.

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

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

70. **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.

Key issues arising from the Review.

71. 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.

72. 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.

73. 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.

74. In March 2022 Mahal contacted Dr Care Anywhere online service with intermittent headaches and reported concerns that his food was being drugged by the government. 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.

75. 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 Mahal murdered Wafiya in front of the children.

Conclusion

76. 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.

77. 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 control[3] 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.

78. 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 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.

79. 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.

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[3] Refuge - What is coercive control?

80. 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.

81. 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.

82. 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

83. 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.

<u>Newham Children's Social Care</u>

84. 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.

<u>Domestic Abuse</u>

85. 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.

86. 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.

87. 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.

88. 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.

89. 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.

90. 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.

91. 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

92. 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.

93. 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.

94. 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

95. 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

96. 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

97. 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

98. 31/05/2019 – Non crime domestic between Mahal and his brother:

99. 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 police were called by Hamza. He told police that Mahal had picked up a knife and a disturbance could be heard in the background.

100. 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.

101. 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

102. 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.

103. 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.

104. 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

105. 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.

106. 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.

107. 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.

108. 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

109. 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

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

Barts Health NHS Trust

111. 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

112. 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.

113. 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.

114. 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.