Domestic Homicide Review

“Tay” who died in January 2021

LDHR22 Overview Report July 2024

Chair: Ged McManus

Author: Carol Ellwood-Clarke QPM

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FAMILY TRIBUTE TO TAY

The below statement was provided by Tay's sister at the conclusion of the court case, and it is the family's wish that it is included within the overview report in its entirety:

"Many will think that today brings justice, closure, time to move forward. In a legal sense, justice has been served. There will never be any justice for the torture Tay endured.

We cannot close the door on the images and sounds of the terror she experienced. As a family, we can't just move forward in a life that exists without Tay.

Time doesn't just heal something so traumatic. Tay was not only violently tortured, we have learnt that she endured abuse prior to the final event. We will never know just how long this lasted and exactly everything she endured.

We have spent the past three weeks hearing every single minute detail of all of the evidence gathered in her case. The 56 sites of injury, videos of her petrified, recordings of her final breaths by the man who caused them. There is no justice for Tay and for us as a family.

Throughout this trial some of us have heard for the first time that this was not a one-off event. I spoke to Tay every day and genuinely saw no signs.

We are left with the guilt of not seeing behind Tay's brave face and wondering why she didn't confide in us. Did she not feel she could? Or did she do it to protect us, and to an extent him? We'll never know.

Throughout this trial we have learnt that Tay did confide in some people. People may wonder why if they knew, why is she not here today? I am sure that those people did not think that the final result would be this. Things like this happen to someone else, not your person.

But unfortunately, this didn't happen to someone else, it happened to Tay. Those people are likely to spend the rest of their lives wondering if they would have done things differently, would the outcome have been different? We'll never know.

This brings me to the complexity of domestic violence as a whole. Tay was a young mum, in a violent relationship. That's complex.

I cannot speak for Tay herself, only what I imagine to be some things that may have ran through her mind. She loved her partner. She thought he was angry because he was unwell. She wanted a happy family.

She wanted her baby to grow up with mummy and daddy. Things got out of hand. She rang the police. She reached out to people for advice when needed. Things would get better. 'It's not that bad'.

But it was that bad. It was so bad that she would eventually go to bed and be so violently attacked that when she would struggle to get him off her, she would not stand a chance. He would attack in her in multiple ways to make sure that she would never come back.

And I know that there will be some people listening to this who may be in a similar position, and a small bit of fear may run through them as they think 'that could be me', but I also know that they will not truly be able to imagine it being them, because their situation is different. Because it's never got that far. Because their situation isn't 'that bad'.

There will also be perpetrators who don't see themselves in the same league because their arguments/abuse has never been 'that bad'. Because the abuse has never resulted in the death of their child, sibling, parent, cousin, friend, the issue isn't 'that bad'.

Tay had had her happiest week in a while. She'd returned to work after maternity leave, her baby had started nursery, she was moving home that very day. Conversations with everyone normal and happy.

And all of a sudden, it was that bad. It was worse than bad. It was painful, and terrifying, and relentless and it took her away forever. Please don't hide this from people to protect them from worry, because you could leave them to endure a lifetime of pain without you and wishing with everything in them that you didn't protect them, because they would have done everything in their power to protect you.

On behalf of my family, I would like to make clear that we stand with anybody suffering from genuine mental health problems. We do not discard the impact that conditions such as PTSD and depression have on people's lives, and we apologise to anybody who has felt personally attacked by his use of these conditions in a bid to get away with it.

Mental health problems are real, and work is still ongoing to lessen the stigma, but the killing of my sister was a purely evil act, with the blame lying solely on his hands, not on an illness.

I would also like to make clear that we stand with asylum seekers fleeing devastation who have the human right to feel safe. We ourselves are the proud descendants of hardworking migrants and believe that everybody deserves a fair chance at life.

We apologise to any innocent asylum seeker who has felt personally attacked by his use of his background in an attempt to excuse his behaviour. The actions of this evil man lie solely on him, and we ask that a time where racial division is still heavily apparent, that people do not assume this man represents a whole group of people.

Tay's story is traumatic, and while we as a family continue to live with and navigate this trauma, we want to at least ease one thing to be given back to Tay. She is more than what happened to her.

Tay was the most hyperactive, hilarious, full of life baby girl. As a girl and teenager, she was shy to those on the outside but cheeky and mischievous to those on the inside. She well and truly had us up the wall with her rebellious bids for independence but to say she would speak her mind for those in need is a massive understatement.

Anyone who knew Tay would tell you she just wanted to help everyone and anyone in need. As a young woman, Tay was independent, hardworking, the most dedicated working mum I ever did see. Every single second was dedicated to her little one.

Although my younger sister, she grew to be and remains my inspiration. Tay was brave, strong, fearless. Everything her child will grow up to be. Tay was and remains ours, we do not want the day to come where we have to accept life without her."

1. Introduction

1.1 The panel offers its sincere condolences to Tay's family.

1.2 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported Tay, a resident of Liverpool, prior to her murder in January 2021. The perpetrator of Tay's murder is Koffi.

1.3 The names of the subjects used in the report are pseudonyms. The pseudonyms for the victim and her child were chosen by her family. The pseudonym for the perpetrator was chosen by the DHR panel from a list of names that are popular in the perpetrator's country of origin.

1.4 This review follows Home Office Domestic Homicide Review statutory guidance (2016)[1]. In addition to agency involvement, the review will examine the past to identify any relevant background or trail of abuse, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.5 In March 2018, Koffi entered the United Kingdom as an unaccompanied asylum-seeking child (UASC). Tay met Koffi in a nightclub in Liverpool and after their relationship started, Tay moved in to live with Koffi. They lived together for approximately eight months, prior to and after the birth of their child. At the time of her murder, Tay had found her own accommodation and had planned to move out of Koffi's property, along with their child.

1.6 In January 2021, Tay was found deceased inside Koffi's accommodation. A Home Office post-mortem examination was carried out, and the provisional cause of death was given as mechanical asphyxiation. Koffi was arrested and later charged with the murder of Tay.

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.7 In the spring of 2022, following a Crown Court trial, Koffi was found guilty of the murder of Tay. In sentencing Koffi, H.M. Judge stated: 'The sentence is custody for life. You will serve a minimum of 19 years less the period of 415 days you have spent on remand. After that, it will be for the Parole Board to determine whether and if so when you should be released. If and when you are released, you will remain on licence for the rest of your life and liable to recall if you commit any further offence or breach the terms of that licence'.

1.8 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse, by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.9 It is not the purpose of this DHR to enquire into how Tay died: this is determined through other processes.

2. Timescales

2.1 On 29 January 2021, Merseyside Police notified Liverpool Community Safety Partnership of the murder of Tay. On 29 April, Liverpool Community Safety Partnership held a meeting to consider the circumstances of Tay's death, against the Home Office Statutory Guidance for undertaking DHRs. A decision was made that the case met the criteria for a DHR, and the Home Office was notified.

2.2 Due to the ongoing criminal investigation at that time, the DHR did not commence immediately. The first meeting of the Review Panel took place on 1 December 2021: where a decision was made to suspend the DHR until the conclusion of the criminal processes.

2.3 A second meeting was held on 30 March 2022. At this meeting, the Review Panel set the period of review from 3 February 2018 to 29 January 2021. The time period was chosen to capture Koffi's entry into the United Kingdom and analyse agency involvement in relation to domestic abuse within the relationship between Tay and Koffi.

2.4 The Domestic Homicide Review was concluded on 5 May 2023 and presented to Liverpool Community Safety Partnership on 20 July 2023 when it was sent to the Home Office.

3. Confidentiality

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	**Ethnicity**[2]
Tay	Victim	20	White British and Black African
Koffi	Perpetrator	18[3]	Black African
Marley	Child of victim and perpetrator	Pre-school age	White British and Black African

[2] Ethnicity for Tay and Marley defined by family.
[3] This is an assessed age: this is covered further in Section 11.

4. Terms of Reference

4.1 The panel settled on the following Terms of Reference at its first meeting on 30 March 2022.

4.2 **The purpose of a DHR is to:**

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.
- (Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

4.3 **Specific Terms**

i. What knowledge did your agency have regarding Tay and Koffi's housing situation and tenancies?
ii. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Tay?
iii. How did your agency assess the level of risk faced by Tay from the alleged perpetrator, and which risk assessment model did you use?
iv. What services did your agency provide for Tay and/or Koffi; were they timely, proportionate, and 'fit for purpose', in relation to the identified levels of risk?

v. Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

vi. How did your agency ascertain the wishes and feelings of Tay and Koffi regarding Tay's victimisation and Koffi's alleged offending, and were their views considered when providing services or support?

vii. How effective was inter-agency information sharing and co-operation in response to Tay and Koffi, and was information shared with those agencies who needed it?

viii. What did your agency do to establish the reasons for Koffi's alleged abusive behaviour, and how did it address them?

ix. Was there sufficient focus on reducing the impact of Koffi's alleged abusive behaviour towards the victim, by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

x. Were single and multi-agency policies and procedures, including the MARAC[4] and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?

xi. How effective was your agency's supervision and management of practitioners involved with the response to the needs of Tay and Koffi, and did managers have effective oversight and control of the case?

xii. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

xiii. What knowledge did family, friends, and employers have that Tay was in an abusive relationship, and did they know what to do with that knowledge?

xiv. Were there any examples of outstanding or innovative practice?

xv. What learning did your agency identify in this case?

xvi. How did your agency take account of any racial, cultural, linguistic, faith, or other diversity issues, when completing assessments and providing services to Tay and Koffi?

[4] Multi Agency Risk Assessment Conference.
A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation, and other specialists from the statutory and voluntary sectors.

5. Method

5.1 On 22 February 2022, Ged McManus was appointed as the Independent Chair, with Carol Ellwood-Clarke appointed as the Independent Author. At the first meeting of the panel, the police requested that the DHR be suspended, pending the criminal trial. This was agreed by the Chair, and the second meeting took place after the conclusion of the trial.

5.2 The second meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format.

5.3 Those agencies with substantial contact were asked to produce individual management reviews, and the others, short reports. The Chair and Author provided training to Individual Management Review (IMR) authors to assist in the completion of the written reports.

5.4 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information was sought.

5.5 In September 2022, the Chair and Author held a practitioner event with frontline practitioners who had worked with and provided services to Tay and Koffi. The meeting was held online using Microsoft Teams. The Terms of Reference were used to facilitate discussions. Information from the event has been included in the report where relevant.

5.6 In the review process, the Chair discussed contact and engagement of Koffi with the panel member from the Probation Service. The Chair was informed by the Probation Service that after the criminal trial and Koffi's conviction of the murder of Tay, he was moved to a mental health hospital. The Chair was informed that due to Koffi's mental health, he would not be able to engage in the review process.

5.7 The Chair and Liverpool Community Safety Partnership experienced significant difficulties in establishing engagement and contact to gather information from United Kingdom Visa and Immigration Service. Requests to obtain information commenced at the start of the DHR process, and despite numerous requests and contact at a regional and national level, the information was provided until the conclusion of the DHR. The information provided was a timeline of events and confirmation that contact was in accordance with policies and processes.

5.8 Thereafter, a draft overview report was produced: this was discussed and refined at panel meetings before being agreed. The draft report was shared with Tay's family, who were invited to make any additional contributions or corrections. Tay's mother attended a Review Panel meeting supported by their Victim Support Homicide Worker.

6. Involvement of family, friends, work colleagues, neighbours, and the wider community

6.1 The Chair was introduced to Tay's mother by her Victim Support Homicide Worker. The Chair provided Tay's mother with details of the DHR proposed timescales and draft copies of the Terms of Reference, and the Chair invited Tay's mother to make comment.

6.2 The Chair and Author visited Tay's mother, who was supported during the meeting by her Victim Support Homicide Worker. Tay's mother provided the Chair and Author with valuable information, which has been included in the report where necessary.

6.3 The Chair spoke to Tay's sister (referred to in the report as Sister 1) via online video conference facilities. She provided the Chair with valuable information, which has been included in the report where necessary.

6.4 The Chair wrote to Tay's father to inform him about the DHR. The Chair did not receive any response from this contact.

6.5 The police provided the Chair and Author with copies of statements obtained during the criminal investigation. Information from these has been included within the report where necessary. A summary of the information is included below but is also captured throughout the report.

6.6 **Father**

6.6.1 In December 2019, Tay's father saw bruising on Tay's arms and face, which he believed to have been caused by Koffi.

6.7 **Half-sister 2**

6.7.1 Half-sister 2 noticed a change in Tay after her relationship with Koffi started. This included a change in her beauty regime (not taking as much pride in her appearance) and having less contact with family and friends. Tay stayed with Half-sister 2 after an incident in November 2020, when she had been physically assaulted by Koffi.

6.8 **Half-brother 1**

6.8.1 Half-brother 1 described incidents of Koffi's control of Tay and disclosures that Tay had made of physical assaults perpetrated by Koffi.

6.9 **Friend 1**

6.9.1 Friend 1 was Tay's closest friend; they had been friends for over 10 years. They were so close that Friend 1 described their relationship as being that of 'sisters'. Tay told Friend 1 about arguments that took place with Koffi. Tay showed Friend 1 injuries sustained from assaults from Koffi. Friend 1 saw these injuries in person and from photographs sent by Tay. Friend 1 witnessed how Koffi spoke to Tay, which she described as being jealous and abusive.

6.10 **Friend 2**

6.10.1 Friend 2 had known Tay for 8/9 years. At the end of December 2019, Friend 2 saw bruising to Tay's arm, which had been caused by Koffi. In November 2020, Tay telephoned Friend 2 and told her that she had been assaulted by Koffi. Tay described incidents when Koffi would take photographs of Tay and threaten to use these as a form of control.

6.11 **Friend 3**

6.11.1 Friend 3 had been Tay's friend since school. Friend 3 described how Tay's relationship with Koffi was happy until Tay became pregnant, at which point they described the relationship as 'rocky'. Friend 3 heard arguments between Tay and Koffi. Tay told Friend 3 of incidents when Koffi had assaulted her.

6.12 **Neighbour 1**

6.12.1 Neighbour 1 lived in the same accommodation block as Tay and Koffi. Neighbour 1 had also known Tay through school, for about 6/7 years. Neighbour 1 described hearing frequent shouting from Tay and Koffi's flat.

6.13 **Work Colleague 1**

6.13.1 Work colleague 1 met Tay in 2018, when Tay started an apprenticeship. They developed a good relationship and met up outside of work. Work Colleague 1 provided details of incidents in January 2021, which included Koffi locking Tay in the bathroom for over an hour and an argument, in the days prior to her murder.

6.14 **College Tutors**

6.14.1 The Chair and Author spoke to two of Koffi's tutors and the ESOL Progress Leader from City of Liverpool College. Tutor 1 was Koffi's tutor from September 2019 until March 2020. Tutor 2 was Koffi's tutor from September 2020 until Koffi's arrest in January 2021. The ESOL Progress Leader supported Koffi's asylum appeal and wrote a letter of support to his application. Further information from this contact is captured in the report where relevant.

6.15 **Employers**

6.15.1 The Chair and Author spoke with Tay's manager and deputy manager. They described Tay as a lovely person, who was easy to get on with and had a clear goal in her life, which she demonstrated by being keen and eager to learn. Tay's manager explained that at the start of the Covid-19 pandemic, Tay was placed on furlough. This was the same process for all 33 staff in their employment, with the exception of the manager. Contact was maintained during this period via emails and WhatsApp messages.

6.15.2 After the birth of Marley, Tay discussed returning to work, and following a return-to-work process, it was agreed for Tay to work two days a week, with Marley attending the nursery on these days. There had been no issues or concerns raised or discussed during the return-to-work process around Koffi, nor were there any references made by Tay in relation to domestic abuse. The Chair was informed that had this occurred, then Tay would have been referred to the Well Being Team, in accordance with the employer's policies and procedures.

6.15.3 Tay was in the process of introducing Marley to the nursery through a phased approach of contact. Tay had recently returned to work at the time of her death.

6.16 **Church**

6.16.1 Contact was made with the resident pastor of the church that Koffi had attended. The pastor provided a copy of two letters that he had submitted to support Koffi's asylum application – these letters stated that Koffi attended at the church and had helped on a few occasions with cleaning and arranging the chairs. The pastor stated that Koffi first attended the church in 2018, and that Koffi had been keen to know more about God and the Bible. Koffi was provided with a copy of the Bible. Koffi's attendance was described as 'seldom'. During lockdown, when church services moved to an online platform, Koffi did not attend. The church reached out to Koffi, but he did not return. Koffi attended at church on two occasions with Tay, whom he described as a 'friend'. Koffi was supported with supply of food items. The

church was not aware of any domestic abuse or other areas of concern between Koffi and Tay.

6.17 **Foster Carer**

6.17.1 The Author spoke to Koffi's foster carer, who had looked after Koffi between June and September 2018. The foster carer described how they had been a foster parent for over 10 years and had experience of looking after asylum-seeking children. Koffi was the first child they had had from the Ivory Coast. The foster carer described that Koffi was 'aggressive' towards her, usually at times when she was giving him instructions. Koffi would often complain that he was being treated unfairly and different to the other children. The foster carer described one incident at mealtime when Koffi banged his plate down on the table and shouted: "I do not like this". The foster carer stated that Koffi got on well with other males in the household, including her extended family. The foster carer stated that there was 'something' about Koffi that put her on edge if they were alone in the house together, and that due to this and Koffi's behaviour, she asked for the placement to be terminated.

7. Contributors to the Review

7.1 This table shows the agencies who provided information to the review.

Agency	IMR	Chronology	Report
Alder Hey Children's Hospital			Y
Bedspace Resource Ltd	Y	Y	
City of Liverpool College			Y
GP Practice for Koffi			Y
GP Practice for Tay and Marley	Y	Y	

Agency	IMR	Chronology	Report
Liverpool City Council, Children's Social Care	Y	Y	
Liverpool City Council, Housing Options Service			Y
Liverpool Lighthouse[5]			Y
Liverpool University Hospitals Foundation Trust			Y
Local Solutions / Liverpool IDVA Service	Y	Y	
Liverpool Women's NHS Foundation Trust	Y	Y	
Mersey Care (including Mental Health/0-19 Service	Y	Y	
Merseyside Police			
North West Ambulance Service			Y
Sanctuary Housing			Y
United Kingdom Visas and Immigration Service			Y

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 Below is a summary of agencies who had not had contact with the subjects of the review:

- Liverpool Hearth & Chest and Community Services
- Liverpool City Council Adult Social Care

[5] https://www.liverpoollighthouse.com/

- Manchester Fire and Rescue Service
- Probation Service
- We are With You
- Whitechapel
- NSPCC
- Targeted Services for Young People
- Our Liverpool
- Anti-Social Behavioural Team
- Liverpool Children's Centres
- Rape and Sexual Abuse Centre
- Liverpool Domestic Abuse Service
- Merseyside Domestic Violence Service
- PSS Ruby Domestic Abuse Service

7.4 Below is a summary of contributors to the review.

7.5 **Alder Hey Children's Hospital**

7.5.1 Alder Hey Children's Hospital cares for over 330,000 children, young people, and their families every year. As one of Europe's biggest and busiest children's hospitals, they treat everything from common illnesses to highly complex and specialist conditions.

7.6 **Bedspace Resource Ltd**

7.6.1 Bedspace's mission is to do one thing: transform the lives of vulnerable people. Whether rescuing someone in urgent crisis or reversing their life course with long-term help. Their uniquely tailored housing and support services are changing lives forever. They are a widely trusted housing organisation, with a team including highly qualified support and outreach workers, right through to bilingual specialists in asylum and Universal Credit.

7.7 **City of Liverpool College**

7.7.1 The City of Liverpool College is one of three colleges of further education in Liverpool, Merseyside. It was established in 1992 by the amalgamation of all

four further education colleges within Liverpool. The College is located over several sites across the city centre.

7.8 Liverpool City Council, Children's Social Care

7.8.1 Children's social care services provided by Liverpool City Council. Careline child services manages all child social care enquiries and referrals.

7.9 Liverpool City Council Housing Options Service

7.9.1 Liverpool City Council's Housing Options Service provides support and assistance to customers who are homeless, or at risk of becoming homeless.

7.10 Liverpool Lighthouse

7.10.1 The projects provide the local community and vulnerable groups with opportunities to develop skills, create and experience arts and culture, and to connect with others, integrated with practical support for people in crisis or who need a helping hand.

7.11 Local Solutions / Liverpool IDVA (Independent Domestic Violence Advocate) Service

7.11.1 Local Solutions is a charity that, since 1974, has been generating and delivering services to support individuals, families, and communities, with a primary focus on those experiencing disadvantage, exclusion, and vulnerability. Their work focusses on serving the communities within Liverpool City Region and North Wales.

7.12 Liverpool University Hospitals NSH Foundation Trust

7.12.1 Liverpool University Hospitals NHS Foundation Trust consists of Aintree University Hospital, the Royal Liverpool University Hospital, Broadgreen Hospital, and Liverpool University Dental Hospital. They serve a core population of around 630,000 people across Merseyside, as well as providing a range of highly specialist services to a catchment area of more than two million people in the North West region and beyond.

7.13 Liverpool Women's NHS Foundation Trust

7.13.1 The maternity team cares for women and their babies from conception to birth, supported by a specialist neonatal team who provide around-the- clock care for premature and newborn babies needing specialist care.

7.13.2 Their fertility team helps families to improve the chance of conceiving babies, and their gynaecology team takes care of women with the many varied conditions associated with the female reproductive system, and it is a renowned centre for gynaecology oncology.

7.13.3 They have a genetics team that supports families with the diagnosis and counselling of genetic conditions and have a dedicated clinical research department that continually improves the healthcare provided to patients and enables the Trust to develop new and improved treatments and medications.

7.13.4 Also, as a teaching hospital, the Trust works closely with the University of Liverpool to deliver the highest standards of undergraduate and post-graduate medical education and training.

7.13.5 Overall, Liverpool Women's represents some of the most outstanding expertise and experience in this field. It is the only such specialist Trust in the UK and the largest women's hospital of its kind, dedicated to the care and well-being of women.

7.14 Mersey Care NHS Foundation Trust

7.14.1 Mersey Care is one of the largest Trusts providing physical health and mental health services in the North West – serving more than 1.4 million people across the region. They are also commissioned for services that cover the North West, North Wales, and the Midlands.

7.14.2 The Trust offers specialist inpatient and community services that support physical and mental health and specialist inpatient mental health, learning disability, addiction, and brain injury services. Clinical services are provided across over 170 sites, spanning a large part of the North West.

7.15 **Merseyside Police**

7.15.1 Merseyside Police is the territorial police force responsible for law enforcement across the boroughs of Merseyside: Wirral, Sefton, Knowsley, St Helens, and Liverpool. It serves a population of around 1.5 million people, covering an area of 647 square kilometres. Each area has a combination of community policing teams, response teams, and criminal investigation units.

7.16 **North West Ambulance Service**

7.16.1 The North West Ambulance Service NHS Trust is the ambulance service for North West England. It is one of 10 ambulance Trusts providing England with emergency medical services, and it is part of the National Health Service – receiving direct Government funding for its role.

7.17 **Sanctuary Housing**

7.17.1 Sanctuary is a housing and care provider. They were set up over 50 years ago to deliver housing and care to those who need it.

7.18 **United Kingdom Visas and Immigration Service**

7.18.1 UK Visas and Immigration (UKVI) is responsible for making millions of decisions every year about who has the right to visit or stay in the country, with a firm emphasis on national security and a culture of customer satisfaction for people who come here legally. UKVI is part of the Home Office.

8. The Review Panel Members

8.1 Review panel members:

Name	Job Title	Organisation
Carole Alker	Service Manager, Permanence, Leaving Care and UASC	Liverpool City Council Children's Social Care
Kerry Dowling	IDVA Operational Manager	Local Solutions / Liverpool IDVA Service
Carol Ellwood-Clarke	Independent Author	
Owain Forsyth	Education and Engagement Officer	Liverpool Safeguarding Children Partnership
Peter Glover	Team Manager (Asylum, NHS & Adult Social Care)	Bedspace Resource Ltd
Michelle Hulse	Team Leader, Victims and Vulnerable People	Liverpool City Council
Paul Grounds[6]	Detective Chief Inspector	Merseyside Police
Esther Golby	Designated Nurse, Safeguarding Children	NHS Cheshire and Merseyside ICB, Liverpool Place
Carmel Hale	Designated Nurse, Safeguarding Adults	NHS Cheshire and Merseyside ICB, Liverpool Place

[6] Was replaced after 5th meeting by Leanne Hobin.

Name	Job Title	Organisation
Beverley Hilton	Risk Assessment Co-ordination Officer	Safer & Stronger Communities Team, Liverpool City Council
Leanne Hobin	Detective Chief Inspector	Merseyside Police
Jenny Hughes-Doyle	Named Nurse, Safeguarding Children	NHS Cheshire and Merseyside ICB, Liverpool Place
Niccie Jones	Training Co-ordinator	Liverpool Safeguarding Children Partnership
Carie Lee	Critical Friend/Observer in relation to Equalities and Diversity	Liverpool City Council
Amanda McDonough	Associate Director of Nursing and Midwifery for Safeguarding	Liverpool Women's NHS Foundation Trust
Ged McManus	Independent Chair	
Debbie Phillips	Domestic Abuse Officer	Liverpool City Council
Lorraine Rock	Safeguarding Lead for Vulnerable Communities	Mersey Care
Danielle Whitwell	Head of North Liverpool Probation Delivery Unit	Probation Service
Stewart Williams	Service Manager	Liverpool City Council Children's Social Care

8.2 The Chair of Liverpool Community Safety Partnership was satisfied that the Panel Chair and Author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met eight times, and the circumstances of Tay's death were considered in detail, with matters freely and robustly considered, to ensure all possible learning could be obtained. Meetings took place using Microsoft Teams video conferencing. Outside of the meetings, the Chair's queries were answered promptly via email or telephone call, and in full.

9. Chair and Author of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors.

9.2 Ged McManus was appointed as the DHR Independent Chair. Ged is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Merseyside). He served for over thirty years in different police services in England (not Merseyside). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

9.3 Carol Ellwood-Clarke was appointed as the DHR Independent Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Merseyside) in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens

Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[7].

9.4 Between them, they have undertaken the following types of reviews: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. In addition, they have undertaken accredited training for DHR Chairs, provided by AAFDA.

9.5 Both have completed previous DHRs[8] for Liverpool Community Safety Partnership.

10. Parallel Reviews

10.1 Following the conclusion of the criminal trial, H.M Coroner determined that an inquest into the death of Tay would not be held, as Koffi had been found guilty and sentenced in relation to the murder of Tay.

10.2 The police completed a criminal investigation into the death of Tay. Koffi was arrested and charged with Tay's murder. In March 2022, following a criminal trial, Koffi was found guilty of the murder of Tay. Koffi received a custodial sentence. [See 1.6].

10.3 Following Tay's death, Merseyside Police completed a Rapid Review, which identified organisational learning. The details of this have been captured within Section 14.

10.4 Following the death of Tay, her GP Practice undertook a significant event analysis. A copy of the report was shared with the Chair and Author. The report documents learning for the GP Practice, which has been captured within this report.

[7] https://safelives.org.uk/
[8] LDHR 20, LDHR 21.

10.5 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication from any agency involved in the review, that the circumstances of the case have engaged their disciplinary processes.

11. Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not

married or in a civil partnership and therefore does not have this protected characteristic].

- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs
- for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[9]

[9] Addiction/dependency to alcohol or illegal drugs are excluded from the definition of disability.

11.3 Tay

11.3.1 Tay had a mixed ethnic background. Tay's family heritage is from Ghana and Sierra Leone. Tay was born in England. English was her first language.

11.3.2 Tay was dyslexic. The Review Panel has seen no evidence that this impacted on Tay's education and employment. Tay had sickle cell disease[10], which is particularly common in people with an African or Caribbean family background. During the Covid-19 pandemic, Tay was classed as vulnerable and had to shield in accordance with Government guidance. Tay had no other known health conditions.

11.3.3 Tay was 17 years old at the beginning of the time period under review and 18 years old when she met Koffi. Tay gave birth to Marley when she was 19 years old. The panel considered that Tay had been a young woman at the time of her relationship with Koffi and the birth of their child. The following research by Women's Aid, details:

11.3.3.1 'Control over pregnancy itself can also be used as a tool of abuse – this form of coercive control is called reproductive control.

11.3.3.2 For example, the abuser may remove or tamper with contraceptives, or deny access to family planning or emergency contraception. This is because an abuser can use a woman's pregnancy as a way of increasing her dependency and intensifying their control over her. Women who experience domestic abuse report a higher-than-average rate of unintended pregnancy. Risks of both unintended pregnancy[11] and domestic abuse during pregnancy are higher for younger and teenage women. Pregnant women find it harder to leave, particularly because of concerns about finance and housing'.

[10] https://www.nhs.uk/conditions/sickle-cell-disease/

[11] Maxwell, L. et al. (2018) Intimate partner violence and pregnancy spacing: results from a meta-analysis of individual participant time-to-event data from 29 low-and-middle-income countries. BMJ Glob. Heal. 3, e000304

11.3.3.3 ‘Prevalence studies suggest that between 20% and 30% of women will experience physical violence at the hands of a partner/ex-partner during pregnancy. About 36% of women report verbal abuse, 14% severe physical violence and approximately 20% of pregnant women reported sexual violence. For many women, domestic abuse begins in pregnancy, while for others it escalates in terms of frequency and severity of violence.[12]’

11.3.4 Domestic homicides and domestic abuse predominantly affect women, with women making up the majority of victims and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report, stated:

11.3.4.1 ‘There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner’.

11.3.4.2 ‘Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)’.

11.3.4.3 ‘Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)’.

[12] https://www.womensaid.org.uk/wp-content/uploads/2019/12/Supporting-women-and-babies-after-domestic-abuse.pdf

11.4 Koffi

11.4.1 On 3 February 2018, Koffi attended at a police station in Liverpool and claimed that he was an unaccompanied asylum-seeking child. Koffi stated that he was 15 years old and was originally from the Ivory Coast[13]. On 4 February, Koffi was served papers as an illegal entrant.

11.4.2 The following day an Asylum screening interview was conducted, and he was assessed by Social Services to be 20 years old. A further assessment was undertaken on 21 June 2018, and he was assessed as being a minor and placed in accommodation by Liverpool City Council Children's Social Care, under Section 20 Children Act 1989[14].

11.4.3 On 4 March 2020, Koffi's asylum claim was refused, and he was given a form of leave that expired on 12 April 2020. Koffi appealed against this decision on the grounds of Article 8 Human Rights Act 1988[15], citing that he was the Father of a British Citizen child. The appeal was granted/allowed by an Immigration Judge on 1 February 2021[16]. Koffi's asylum and Looked After Care status are covered further in Sections 13 and 14.

11.4.4 In May 2018, an age assessment concluded that Koffi was 15 years old, with a birth date of October 2002. Koffi's birth date and name varied in agency records. For the purposes of the DHR, the Review Panel has used the birth date from the assessment in May 2018.

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[13] Ivory Coast, also known as Côte d'Ivoire, officially the Republic of Côte d'Ivoire, is a country on the southern coast of West Africa. Its official language is French, and indigenous languages are also widely used. In total, there are around 78 different languages spoken in Ivory Coast. The country has a religiously diverse population, including numerous followers of Christianity, Islam, and indigenous faiths. In 1999, there was a coup d'état in 1999, then two civil wars — first between 2002 and 2007 and again during 2010–2011. It adopted a new constitution in 2016.

[14] https://www.legislation.gov.uk/ukpga/1989/41/section/20#:~:text=20%20Provision%20of%20accommodation%20for%20children%3A%20general.&text=(3)Every%20local%20authority%20shall,not%20provide%20him%20with%20accommodation.
Provision of accommodation for children: general.
(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of—
(a)there being no person who has parental responsibility for him.
(b)his being lost or having been abandoned; or
(c)the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

[15] https://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/7#:~:text=Article%208%20Right%20to%20respect,his%20home%20and%20his%20correspondence.

[16] On 31 March 2021, records held by the Home Office state that they would not be issuing him his leave.

11.4.5 Koffi is a black African. Koffi's first language is French. Koffi did not speak English when he came to the United Kingdom. During contact with professionals, Koffi needed the support of an interpreter. Koffi attended courses in Liverpool to learn the English language, and the Review Panel heard that over time, Koffi's use of the English language improved in day-to-day discussions.

11.4.6 Koffi stated that as a child, he had been brought up as a Muslim. After coming to the United Kingdom, Koffi started to attend a local church, as he stated that he had wanted to convert to Christianity. The Review Panel has not identified that Koffi was a practicing Muslim or that he had been, or was, visiting mosques.

11.4.7 During Koffi's Initial Health Assessment[17], undertaken whilst he was living in Manchester, it was identified that he had experienced significant trauma, and a referral was made to psychological services; however, Koffi then moved from Manchester and returned to the Liverpool area, and it was unclear if the referral was progressed. On 18 September 2019, Koffi was referred to Talk Liverpool[18] by a GP, due to low mood and symptoms of trauma. This was one of two referrals made to Talk Liverpool during the time period of the review. Koffi's health records detailed that Koffi had a history of depression, suicidal ideation, thoughts of deliberate self-harm, and impulsivity. Koffi was prescribed fluoxetine[19] by a GP in response to his mental health. Details of engagement with Talk Liverpool is covered further in Sections 13 and 14.

11.5 **Marley**

[17] When a child/young person comes into care, they will have an Initial Health Assessment (IHA) – this is a statutory health assessment that is required to be completed within 28 days of them coming into care. The assessment is completed by a paediatrician who looks at the child/young person's health and well-being.

[18] https://www.talkliverpool.nhs.uk/about-us/
Talk Liverpool is an improving access to psychological therapies (IAPT) service. This means we aim to get you the right help at the right time. It also means we only use psychological therapies that have been shown by research to help with depression and anxiety. Talk Liverpool is part of Mersey Care NHS Foundation Trust – improving the lives of the people of Liverpool is at the heart of what we do.

[19] https://www.nhs.uk/medicines/fluoxetine-prozac/
Fluoxetine is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and sometimes obsessive-compulsive disorder and bulimia.

11.5.1 Marley received support from the Pre-School Healthy Child Programme[20].

11.5.2 There is nothing in agency records that indicated that any of the subjects lacked capacity[21], in accordance with Mental Capacity Act 2005.

12. Dissemination

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process:

- The Family
- Liverpool Community Safety Partnership
- Liverpool Safeguarding Children Partnership
- All agencies that contributed to the Review
- Merseyside Police and Crime Commissioner
- Domestic Abuse Commissioner

13. Background, Chronology and Overview

13.1 This part of the report combines the Background, Chronology and Overview sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings

[20] The 0-19 Healthy Child Programme is a nationally developed evidenced-based programme that is available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.

[21] The Mental Capacity Act 2005 established the following principles:
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.
Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
(Mental Capacity Act Guidance, Social Care Institute for Excellence)

to aid understanding. The information is drawn from documents provided by agencies and information following engagement with family and friends.

13.2 Of note, during the completion of this review, there were over 700 contacts between Koffi and professionals from Bedspace. Many of these entries relate to daily contact with Koffi – for matters such as transportation to appointments, budgeting, shopping, household chores, and inspection of accommodation. This section will only reference entries that are relevant for the purposes of the DHR.

13.3 Tay had limited contact with professionals during the early timescales of the review; and whilst this provides an imbalance in the following section, the Review Panel have included all entries in which Tay had contact with professionals.

13.4 Merseyside Police use the MeRIT[22] risk assessment tool to evaluate domestic abuse incidents. The VPRF1 (which includes the MeRIT risk assessment tool) contains 40 questions formulated to illicit information from the parties about the incident and the state of the relationship between them. The questions are divided into three sections: a violence assessment; a breakdown assessment; and a social assessment. The answers calculate a score, which in turn provides a bronze, silver, or gold grade: gold indicating the most serious level of risk.

13.5 Note: Not all agencies in Merseyside use MeRIT. Some health agencies use the DASH risk assessment.

13.6 **Tay**

13.6.1 Tay was a funny, loving, kind person who had a big heart. Tay always saw the good in people. Tay was a mischievous child growing up. Tay was attentive to other people's emotions and often supported other people if they had difficulties.

[22] Merseyside Risk Identification Tool

13.6.2 As a teenager, Tay was a little shy and not very confident socially. Tay was dyslexic: this caused a lack of confidence in her own abilities. Tay struggled to some extent with the challenge of being from a mixed ethnic background in an area where people were from a white background. Tay worked hard at school, but it was not until she left school at 16 that her mother stated that she started to bloom.

13.6.3 Tay obtained an apprenticeship working in a nursery in Liverpool. Tay's family had moved away from Liverpool at this time, and Tay would travel daily from their home address to Liverpool. This entailed a 3 hour travel each way (a variety of methods were used, such as train, bus, etc.). Tay loved her job and was determined to make a go: she would get up early each day to travel to work.

13.6.4 When Tay's apprenticeship finished, she found a placement as a nursery nurse. Tay loved her job, and the children that she cared for, loved her.

13.6.5 After the birth of Marley, Tay intended to go back to work and had sourced a place for Marley at the nursery in which she worked. Marley settled in quickly at the nursery. Tay had recently returned to work at the time of her murder.

13.7 **Koffi**

13.7.1 Koffi told professionals that he had witnessed the murder of his mother and father. Koffi then lived with an uncle who was physically violent towards him. Before he came to the United Kingdom, Koffi fled the Ivory Coast and travelled to France. Koffi told the police that he travelled from London to Liverpool via train.

13.7.2 During an Initial Health Assessment completed by Mersey Care, Koffi stated that he had experienced significant trauma prior to his journey to the United Kingdom. Koffi had shared examples of physical abuse: that he witnessed a friend being shot; that he saw three people thrown overboard from a boat; and that he had been threatened to be murdered due to his religion.

13.7.3 For most of the time period of the review, Koffi was a child[23] and was cared for by Liverpool City Council Children's Social Care, in accordance with legislation. Koffi was initially placed in accommodation provided by Bedspace; however, following an age assessment completed in May 2018, which identified that he was 15 years old, he was placed with foster carers. Koffi returned to accommodation provided by Bedspace in January 2019; at which time, he was 16 years old.

13.7.4 Koffi had a support worker who helped with payments for his accommodation, gas and electricity, and visited him weekly to give him money. The support worker also brought his medication. Koffi attended local colleges in Liverpool and studied English. Koffi also participated in football in the community with a local football team.

13.8 **Tay and Koffi's relationship**

13.8.1 Tay met Koffi in a nightclub in Liverpool. Koffi told Tay that he had come from a troubled background. Tay's mother told the Chair that Tay had wanted to give him a family setting and a background in which he felt wanted.

13.8.2 Tay moved in with Koffi around the spring of 2020. They had a child together, Marley.

13.8.3 Tay's mother stated that whilst Koffi spoke French, he did speak and understand English. Tay did not speak French and conversed with Koffi in English.

13.8.4 On the morning of Tay's death, she was due to move out of the accommodation that she shared with Koffi. Tay had sourced her own place and had wanted to move out for independence. Tay's mother told the Chair

[23] https://learning.nspcc.org.uk/child-protection-system/children-the-law#:~:text=England,living%20independently
The United Nations Convention on the Rights of the Child (UNCRC) defines a child as everyone under 18 unless, "under the law applicable to the child, majority is attained earlier". In England a child is defined as anyone who has not yet reached their 18th birthday. Child protection guidance points out that even if a child has reached 16 years of age and is:
living independently
in further education
a member of the armed forces
in hospital; or
in custody in the secure estate
they are still legally children and should be given the same protection and entitlements as any other child (Department for Education, 2018a).

that it had always been Tay's intention, and that Koffi was aware of the move and Tay's wishes. Tay had placed a deposit on the property, which was a two-bedroom apartment.

13.9 **Summary of events prior to Timescales of the Review**

13.9.1 In February 2015, Children's Social Care received a referral from Tay's school that Tay had disclosed that her father hit her mother. This relationship had ended in 2008 and related to incidents that had occurred prior to this time.

13.10 **Events during the Timescales of the Review**

13.11 **2018**

13.11.1 On 3 February, Koffi attended at a police station in Liverpool and stated that he had arrived in the country the day before as an unaccompanied asylum seeker. Koffi was initially placed in adult accommodation having been assessed as an adult, before a move to semi-independent placement on 16 March 2018.

13.11.2 In June 2018, an age assessment was undertaken of Koffi. The outcome determined that Koffi was 15 years old, which resulted in plans commencing to move Koffi to alternative accommodation. This included familiarisation visits to other areas by his support worker. Koffi was accommodated under Section 20 Children Act 1989. Children's Social Care completed a single assessment.

13.11.3 Between 22 May and 1 August, three appointments were made for Koffi to attend for an Initial Health Assessment. Koffi was not taken to any of the appointments.

13.11.4 On 19 June, Koffi attended a Looked After Child meeting where discussions were held about a potential foster placement. On 25 June, Koffi moved to live with foster carers. This placement was within Liverpool.

13.11.5 On 10 July, Koffi was seen by a social worker in his foster placement. During the visit, it was documented that Koffi got on well with the male foster

carer but when the female foster carer tried to communicate, Koffi 'scowled'. In a visit two weeks later, it was documented that whilst things had improved, Koffi was still not engaging with the female foster carer but continued to have an excellent relationship with the male foster carer. The female foster carer requested that Koffi's placement was terminated.

13.11.6 Following access to the report, the family asked whether there had been any changes to Koffi's care plan, following the termination of the foster carer placement. The Review Panel was informed by Children's Social Care that there was no evidence in Children's Social Care files of relationship differences; therefore, there were no changes to Koffi's care plan.

13.11.7 On 5 September, Koffi moved to semi-independent living accommodation in Manchester. The reason for the move was not clear. Koffi had started to learn English and maths. Koffi remained in this accommodation until 17 January 2019. Koffi had registered with a GP in Manchester. The Review Panel has been unable to gather information from Koffi's care provider (whilst he was living in Manchester) because the company did not respond to repeated communication by email, telephone, and letter.

13.11.8 On 12 October 2018, Koffi's Initial Health Assessment was completed. This recorded an action for psychological support to be provided by February 2019. However, this was not completed prior to Koffi's return to Liverpool in January 2019.

13.11.9 On 30 November, during a visit to see Koffi at his placement, staff stated that Koffi could be 'demanding and moody' when he did not get his own way, that he attempted to dictate which staff he would like to be on duty, and that he refused to engage if certain staff were involved.

13.11.10 On 21 December, a discussion was held between the Independent Reviewing Officer and team manager. Concerns were raised about the planned move of Koffi from foster care to semi-independent living. The team

manager shared that they were concerned about Koffi's behaviours – namely, threats towards a female member of staff.

13.12 **2019**

13.12.1 On 9 January, Koffi was seen by a social worker. It was recorded that Koffi had made a complaint in relation to the registered manager of the care provision, and that the complaint had been upheld. Koffi was keen to relocate from Manchester to Liverpool. Children's Social Care had limited details of the complaint, which stated: 'Carer requests placement end other than due to child's behaviour'.

13.12.2 On 17 January, Koffi moved to Liverpool into accommodation provided by Bedspace. Koffi registered with two local colleges and was placed on a waiting list. Whilst a space became available, it was documented that Koffi was doing his own work on English and maths.

13.12.3 On 2 February, Koffi was visited by a social worker. There was no previous record held by Children's Social Care of the move to Bedspace.

13.12.4 On 27 June, Koffi's support worker undertook some work with Koffi on sex education and healthy relationships. Koffi was also provided with leaflets on sex education and addresses should he need further help.

13.12.5 On 16 July, Koffi's support worker contacted the police to report Koffi as a missing person, as they had been unable to make contact with him for four days. Koffi was found by his support worker. Koffi had not been missing; he had chosen not to answer calls from the support worker.

13.12.6 On 23 July, Koffi's social worker spoke to his support worker about the 'missing' incident. The support worker stated that if 'he cannot get his own way, then he behaves very childlike and can be difficult with staff and will avoid them and not tell them where he is'. The support worker further described Koffi as 'an angry young man and gets very jealous if any of the other young people are receiving attention or if they are in the car when he is in the car'. It was also reported that other residents did not know if they could

have a ‘laugh’ with him, as he appeared to be unpredictable and ‘always changing’.

13.12.7 On 7 August, Koffi was accepted onto the Children in Care health caseload and was sent a letter of introduction.

13.12.8 On 14 August, during a Looked after Child Review, it was recorded that whilst Koffi had been living in Manchester, he had visited a GP, suffering with low mood and sleep issues. Koffi had been prescribed medication, which he took for two weeks. It was documented that there was no record that Koffi had received psychological therapy support, as had been indicated within the Initial Health Assessment, to support his trauma.

13.12.9 In September 2019, Koffi started to study at City of Liverpool College. Teacher 1 described that Koffi was involved in three incidents in class where he displayed aggressive behaviour towards other students. The behaviour was not physical and not directed at Teacher 1: it was described as emotional outbursts towards other students who he thought were laughing at him.

13.12.10 On 18 September, Koffi was referred to Talk Liverpool by a GP for low mood and symptoms of trauma. A face-to-face appointment was made for the following week; however, this had to be rescheduled as Koffi arrived late and an interpreter did not attend. A further appointment was arranged, which was cancelled by Koffi.

13.12.11 On 26 September, Koffi attended a statutory Review Health Assessment: no concerns were documented regarding general development or educational progress. Within the health assessment, Koffi stated that he was not in a relationship and knew what a healthy relationship was.

13.12.12 On 17 October, Koffi’s college contacted Koffi’s support worker to discuss Koffi’s behaviour in college, whereby he had been verbally abusive to another student.

13.12.13 On 24 October, Talk Liverpool cancelled Koffi’s face-to-face assessment.

13.12.14 On 6 November, Koffi's college contacted Koffi's support worker about Koffi's behaviour. A meeting was arranged.

13.12.15 On 7 November, Koffi attended a face-to-face assessment at Talk Liverpool. A treatment plan was offered, in line with National Institute for Health and Care Excellence (NICE) guidance for Post Traumatic Stress Disorder (PTSD) Clinical Model[24].

13.12.16 On 8 November, a meeting was held at the college with Koffi, his support worker, tutor, and another college representative. Koffi's tutor discussed that Koffi had a negative attitude in class and swore a lot, which changed the atmosphere and caused other students to be unhappy. Koffi stated that he felt that the tutor did not like him, favoured other students, and that he was not treated fairly. Koffi was advised to change his negativity and inform his tutor when he was feeling low. Teacher 1 stated that after this meeting, Koffi's behaviour and attitude improved.

13.12.17 On 19 November, Koffi provided a statement to his solicitor (with the help of an interpreter) in relation to his asylum application.

13.12.18 On 3 December, Koffi's support worker visited his tutor, who stated that since the meeting held in November, Koffi's attitude had changed, and he was paying attention in class.

13.13 **2020**

13.13.1 On 13 January, Tay attended at the Emergency Department at Royal Liverpool Hospital with abdominal pain. Tay was discharged with analgesia.

13.13.2 On 22 January, during a Looked after Child review meeting, it was documented that Koffi's mood was low and that he had not had a repeat medication prescription collected due to his support worker being on leave.

[24] https://www.nice.org.uk/guidance/ng116

Records held by Bedspace, documented that his medication had been collected by a support worker that day.

13.13.3 On 4 February, Tay attended at the Emergency Room at Liverpool Women's Hospital. Tay was in the early stages of pregnancy and reported lower abdominal discomfort. Tay attended alone. Tay was asked routine enquiry about domestic abuse: no concerns were identified.

13.13.4 Three days later, Tay attended at the Early Pregnancy Unit at Liverpool Women's Hospital. Tay was accompanied by Koffi. Tay was discharged, with advice for ongoing pregnancy. Routine enquiry was not undertaken. This was the first agency record that Tay and Koffi were in a relationship.

13.13.5 On 14 February, Koffi had an asylum interview.

13.13.6 On 20 February, Tay attended her first antenatal appointment. Tay provided Koffi's details as the father of her baby; however, the details contained a different date of birth.

13.13.7 Information provided by Tay, documented that she and Koffi were living at different addresses. Routine enquiry was completed, with no concerns identified. Liverpool Women's Hospital had no record that Tay and Koffi were living together.

13.13.8 The same day, Tay approached Housing Options Service for rehousing advice, relating to Property Pool Plus. Tay stated that she was residing with a friend and wished to secure her own accommodation before the birth of her child.

13.13.9 On 28 February, Koffi telephoned 111 and expressed suicidal ideation. Koffi was tearful and distressed and reported plans to harm himself by jumping into water. Koffi reported that he lived alone and had no protective factors. Koffi was seen by the Triage Car and ambulance and was taken to the Emergency Department. Koffi left hospital without being seen.

13.13.10 A Mental Health Liaison Team practitioner contacted Koffi via his mobile phone. Koffi stated that he was feeling much better and had arrived home safely. Crisis pathway information was provided, and he was advised of Young People's Advisory Service[25] (YPAS), Headspace[26], and Calm Against Living Miserably (CALM) services[27]. The Review Panel saw no evidence that Koffi contacted these services. Koffi stated that he would visit his GP and denied any further thoughts to harm himself.

13.13.11 On 4 March, Koffi's asylum application was refused. On 9 March, Koffi's solicitor informed his support worker that his asylum application had been rejected and that an appeal would be commenced. Three days later, Koffi moved to another accommodation provided by Bedspace.

13.13.12 On 16 March, Tay attended the Emergency Department at Liverpool Women's Hospital with abdominal pain. Tay was accompanied by Koffi. Tay attended a follow-up appointment the following day. Tay was alone at this second visit. During this visit, routine enquiry was undertaken. No concerns were identified nor disclosures of abuse.

13.13.13 On 18 March, Koffi's support worker informed his social worker of Tay's pregnancy and that they were living together. Koffi had described Tay as his best friend and confidant. This is the first record that Tay and Koffi were living together. The support worker also informed Koffi's solicitor.

13.13.14 On 23 March, the then Prime Minister [Johnson] told people they "must" stay at home and said that "we will immediately" close some businesses. This had been referred to as the start of lockdown by Government ministers, including Messrs Hancock and Johnson.

[25] https://ypas.org.uk/
Providing mental health and emotional well-being services for Merseyside's children, young people and families.
[26] The Headspace App: https://www.headspace.com/
[27] https://www.thelivewelldirectory.com/Services/226

13.13.15 On 26 March at 1 pm, the main Covid-19 restrictions in England began, when The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 came into force.

13.13.16 On 28 March, a mental health nurse from Mersey Care contacted Koffi's support worker for an update on his mental health. The support worker stated that Koffi was feeling much better but had, on one occasion, stated that he felt like jumping from a very high building. However, later that day, he stated that he was looking forward to his 'small new family', and that he gets 'positive vibes' from his girlfriend, which makes him very happy, and that he 'will live because of his baby'.

13.13.17 On 9 April, Children in Care Service (which is part of Mersey Care) undertook a review of Koffi's health, in line with internal processes due to the Covid-19 pandemic. Koffi was rated 'Red' in the Red, Amber, Green (RAG) ratings, due to his recent mental health concerns. It was determined that weekly contact would take place as part of the care plan; however, Koffi was never spoken to directly, other than during his Review Health Assessments. Therefore, his voice was only heard via professionals, between April and June 2020. This is addressed in Section 14.

13.13.18 On 9 April, Koffi's support worker installed 'Zoom' onto Tay's mobile phone, to allow Koffi to undertake video calls with professionals. The same day, Koffi had a 'Zoom' meeting with his solicitor, support worker, and interpreter: the outcome of his asylum application was discussed. Koffi stated that he felt let down by the 'system' and that he felt like 'running mad'. Koffi's support worker agreed to contact his GP to arrange an appointment. This was completed eight days later.

13.13.19 On 20 April, Mersey Care received a telephone call from Children's Social Care. During the call, Mersey Care was informed that Koffi had a girlfriend who was three months pregnant. There was no record that details of the girlfriend were shared, which had it been, may have allowed for their health records to have been linked.

13.13.20 On 27 April, Koffi had a video call with his social worker. This appeared to be the first record of any contact for some time. It was noted that Koffi had been spending significant time with his girlfriend, who was pregnant.

13.13.21 On 29 April, Talk Liverpool sent an appointment to Koffi via Short Message Service (SMS) messaging. The appointment had been arranged for 15 May. The text was rejected and therefore not received by Koffi. When Koffi did not attend on 15 May, he was discharged from the service.

13.13.22 On 13 May, a mental health nurse (from Mersey Care) contacted Koffi's support worker for an update on his mental health. The support worker shared that Koffi had recently started to feel lonely when his girlfriend was not around, and that Koffi had stated that he needed to see his girlfriend, as his mental health would decline.

13.13.23 On 14 May, Tay applied for Property Pool Plus[28]. Tay was awarded band A[29] (for a two-bedroom property), due to overcrowding. The same day, Tay had a telephone appointment with a community midwife. Tay had not attended her 16-week appointment, four weeks earlier. Since that time, there had been attempts to contact her to discuss the results of initial blood screening and arrange screening of Koffi. The initial blood screening had identified Tay as having Beta Thalassemia trait[30]. Koffi attended for screening on 3 June.

13.13.24 On 26 May, a Child in Care nurse (from Mersey Care) contacted Talk Liverpool to advise that Koffi had moved accommodation. Updated contact details were provided, and Talk Liverpool agreed to arrange a further appointment. A further appointment was arranged for 15 June. However, this was sent to Koffi's old mobile phone number; therefore, he did not attend, and he was discharged from the service.

[28] Property Pool Plus gives priority to local people who need a home and cannot afford to buy or rent privately.
[29] Band A includes people living in unsatisfactory housing from which they have to move.
[30] Pregnant women with beta thalassemia can develop anaemia, which can raise the chances of delivering early. They may need more frequent blood transfusions during pregnancy for their health and the health of the baby.

13.13.25 On 3 June, Mersey Care reduced Koffi's RAG rating to 'Amber'. Whilst it was documented that Koffi was reported to be taking his medication, he had not yet been seen by Talk Liverpool at this time. However, there had been six telephone contacts with a support worker between 17 April and this day. Records of these contacts, documented Koffi's mood as 'good, no concerns, taking exercise, had a GP review, healthy and happy and involved with the church'.

13.13.26 On 16 June, Koffi's support worker sent an email to his social worker in response to questions about Koffi's girlfriend and any safeguarding concerns about the unborn baby. The contact had been generated to advise of Tay's pregnancy.

13.13.27 On 19 June, during a Looked after Child review, it was documented that Koffi was on a higher dosage of medication and was awaiting another appointment with Talk Liverpool. The Independent Reviewing Officer, who chaired the meeting, agreed to provide some equipment for the baby. It was agreed that Koffi should be supported to apply for a two-bedroom house on Property Pool Plus. There was no record that an application had been made.

13.13.28 On 30 June, a Child in Care nurse (from Mersey Care) contacted Talk Liverpool to request that Koffi be reinstated. Koffi's updated contact details were provided again, as the previous mobile phone number had proved unsuccessful when contacting Koffi. It was agreed at this point that Koffi would be reinstated; however, it was later identified that Koffi was expected to have a new telephone assessment as he had not responded to previous calls and therefore was classed as a 'new episode'. The Children in Care nurse challenged this decision, as Koffi had completed an initial telephone assessment. On 18 August, it was agreed with Talk Liverpool that Koffi would receive a telephone assessment, with the wait time for any identified therapy to take into consideration the time he had been on the waiting list.

13.13.29 On 27 July, Koffi was referred to Talk Liverpool by a GP.

13.13.30 On 17 August, Koffi was visited by a newly allocated social worker. Koffi discussed that he had been in a lot of distress and that he felt the previous social worker had not been able to provide the support he needed. Koffi shared concerns about having to work as a gardener in a previous foster placement. The same day as this visit, Tay registered with a GP in Liverpool.

13.13.31 On 18 August, a Child in Care nurse (from Mersey Care) contacted Talk Liverpool to escalate Koffi's appointment. An appointment was arranged for 28 August 2020.

13.13.32 On 19 August, Koffi's support worker accompanied him to the Red Cross to seek help in locating his sister.

13.13.33 On 22 August, Koffi's newly appointed social worker emailed his solicitor regarding Koffi's immigration status. Within the email, it was documented that Koffi was extremely distressed, given the uncertainty around his immigration status: this appeared to have significant impact on his emotional well-being. The email also detailed that Koffi was on medication, and that there was no record held by the local authority as to rationale for the refusal of his immigration status. The social worker questioned as to whether a psychological report would support his claim and character references.

13.13.34 On 26 August, Tay was registered on Liverpool Community Services antenatal records. Tay was contacted by a health visitor and offered a virtual birth visit. Tay requested a telephone call. A virtual call was routine practice at this time due to the Covid-19 pandemic.

13.13.35 On 28 August, Koffi's support worker met with the Independent Reviewing Officer to discuss the support to be offered to Koffi when he turned 18, as he had expressed worries. The support worker was informed that Koffi would be allocated a personal advisor.

13.13.36 The appointment due to be held by Talk Liverpool with Koffi on 28 August, was cancelled due to staff sickness.

13.13.37 On 9 September, Koffi had a telephone assessment with a practitioner from Talk Liverpool. This was the same practitioner who had conducted Koffi's face-to-face assessment in November 2019. The outcome of the assessment agreed to offer low intensity support for trauma symptoms.

13.13.38 On 13 September, Tay was admitted to hospital due to pregnancy-related matters. Tay gave birth whilst in hospital and was discharged home on 23 September.

13.13.39 Between 23 September and 4 November, Koffi attended seven weekly sessions with a psychological well-being practitioner. These sessions took place via Language Line. The focus of the sessions was behavioural activation for depression and risk management. This is analysed further in Section 14.

13.13.40 On 24 September, Tay, Marley, and Koffi were seen at Koffi's accommodation by a community midwife. Routine enquiry was not completed due to Koffi being present during the visit. A further visit was completed three days later.

13.13.41 On 30 September, an Annual Review Health Assessment[31] was completed with Koffi. This took place face to face. Koffi disclosed that his asylum application had been denied. The assessment documented: 'He knows what a "Healthy Relationship is" and was able to identify what an unhealthy relationship looked like' However, there were no examples of what "healthy" was to Koffi. The Review Panel was informed by Mersey Care that examples do not have to be provided, although can be supportive when trying to understand need. It was identified by a school nurse that Koffi had not been allocated a named health professional, even though he had been residing in Liverpool for eight months.

13.13.42 On 5 October, Tay had a telephone consultation with a health visitor as part of the initial birth visit for Marley. Tay reported that both parents felt well

[31] Annual Review Health Assessments are statutory for all children 5-18 years old.

(physically and emotionally), that there was good support from her family, and that she had a supportive, safe relationship with her partner.

13.13.43 Tay reported that she and her partner were enjoying their new baby and adjusting to being parents. At the end of the contact, it was agreed to contact with universal and open access.

13.13.44 On the morning of 6 October, Tay requested the community midwife to sign the Maternity Grant Form. The midwife asked for them to attend the clinic she was working from, and Tay, Koffi, and Marley were seen by a community midwife at a GP clinic. Tay reported that they were coping well with the new baby.

13.13.45 On 6 October at 10 pm, Tay contacted the police via a 999 call. Tay stated that Koffi had grabbed her, put his fingers down her throat, and prevented her from leaving the flat with Marley. Tay sustained bruising on her arm. Tay told the police that she had been trying to leave the accommodation to stay in a hotel with Marley and that about an hour before the incident, Koffi had taken a double dose of his medication, which she stated he did when he felt that the medication was not working. Tay described other incidents where Koffi had been verbally abusive towards her.

13.13.46 Koffi was not at the flat when the police attended. Tay provided a statement and agreed to photographs being taken of her injuries. The police completed a Vulnerable Person Risk Form 1 (VPRF1) and graded the risk as gold. Koffi was circulated as a wanted person on the Police National Computer (PNC). The case was referred to MARAC. The Review Panel understands that Tay moved out of Koffi's accommodation after this incident (to stay with family), but that she did visit and stay over on occasion.

13.13.47 On 6 October the Home Office received information that Koffi claimed to be the Father of a British Citizen child and asked that Article 8 Human Right Act 1988 be considered as part of his appeal. The domestic abuse incident was not known to the Home Office.

13.13.48 On 7 October, Tay provided a further statement to the police, in which she stated that she no longer supported a prosecution. Tay told the police that she had placed a deposit on a new property, in which she was planning to move to with Koffi. Tay also stated that she was unsure if she would continue the relationship with Koffi. The police finalised their case. Koffi was not seen or spoken to by the police.

13.13.49 On 12 October, Koffi turned 18 and was no longer a Looked after Child: he was subsequently allocated a Leaving Care personal advisor.

13.13.50 The same day, an IDVA telephoned Tay. Tay was provided safety advice and details of the support that could be provided. It was documented that Tay was unsure if she needed ongoing support but agreed to further contact from the IDVA. The IDVA telephoned other agencies in contact with Tay and Marley. The IDVA was informed by Careline that the incident would be passed to a social worker for screening and decision-making on the next steps.

13.13.51 On 13 October, Mersey Care received the VPRF1 from the Liverpool Women's Hospital, following the incident on 6 October. The case was not allocated to a named health visitor at this time, as the case was being managed at a universal threshold. The following day, a MASH[32] information sharing request was received in readiness for the MARAC. The form did not contain Koffi's details; therefore, his information was not shared. This is analysed further in Section 14.

13.13.52 On 15 October, Children's Social Care commenced a single assessment. This was completed on 11 December 2020. During the completion of the assessment, Tay, Koffi, and Marley were seen by a social worker. The social worker did not speak with, or gather information from, Koffi's personal advisor. This is covered in Section 14.

13.13.53 On 21 October, a health visitor enquired with the team leader, if a named health visitor should be allocated to support the family due to the

[32] Multi Agency Safeguarding Hub

incident on 6 October. Marley was allocated a named health visitor on 24 November, following discussion with Careline. Although a named health visitor was not allocated, the Review Panel was informed that the health visitor completing the birth visit and follow-up birth visit, holds the same qualifications and delivers the same information at each mandated contact. The Review Panel was informed that Mersey Care currently has no standardised process following an incident of domestic abuse or receipt of a VPRF1. This is covered further in Section 14.

13.13.54 The same day, an IDVA telephoned Tay, as had been agreed. Tay stated that a social worker had visited the address and spoken to her and Koffi. Tay agreed to a further call from the IDVA. No support needs were identified during the contact.

13.13.55 On 26 October, the health visitor team leader received a telephone call from a social worker, which detailed an unannounced visit that had been made to see Tay and Marley. During the visit, Koffi had admitted to covering Tay's mouth when she screamed during the incident in October. Koffi stated that he was anxious about the baby. It was documented that the social worker had stated that Koffi's anxiety and him not taking his medications properly, had led to the argument. The social worker advised that they would explore what was available in the community, in ways of classes for Koffi, and that that they intended to close the case as Tay had acted appropriately. No specific classes were identified. Tay and Koffi were referred to the local Children's Centre to access support for parenting. The single assessment highlighted that a number of agencies were involved with Koffi and Tay and were available for advice and support.

13.13.56 On 30 October, a community midwife telephoned Tay. Routine enquiry was completed. No further concerns were raised. Tay had been transferred to health visiting services. Liverpool Women's Hospital had received a VPRF1 from Merseyside Police and a MASH enquiry form for the MARAC hearing on 5 November. Tay was discharged from maternity services. At point of discharge, Tay was being supported by other agencies.

13.13.57 On 4 November, Talk Liverpool agreed to step Koffi up to cognitive behaviour therapy (CBT). The therapy model is appropriate for post-traumatic stress disorder (PTSD) and in line with NICE guidance.

13.13.58 On 5 November, Koffi was seen by his support worker. During the visit, the following account was recorded: 'he told me that he is not happy with his girlfriend. She does not treat him well. She allows her family to visit whenever they wish too, but as his own people visit, she becomes angry and don't anyone to carry the baby. He feels that she has taken over his home. He spends the time sitting on the sofa. He is always shouted at and speaks down too. He does all the housework as she; can't do anything, She annoys him all the time and he feels like walking away but because he loves his baby he will stay. He wants her to move out as she monitors all he does. Her friends visited he was unhappy as they drank lots of alcohol and when they left, he carried the baby and his girlfriend snatch the baby away from him though he did not want her to carry the baby because she had drunk alcohol. The next day, she apologized and promised never to do it again. He said she can't cook; clean not do anything'.

13.13.59 The Review Panel acknowledges that the above entry can be seen as victim blaming but have included it in this section as a record of information provided by Koffi to a professional.

13.13.60 The support worker contacted Koffi's personal advisor and was informed of the domestic abuse incident on 6 October. This was the first time that the support worker and/or Bedspace were aware of the incident.

13.13.61 A MARAC was held on 5 November. The meeting recorded that Tay and Koffi had joint tenancy of their accommodation. This was incorrect. There were no details of Tay and Koffi's housing provider, which resulted in Bedspace not being invited or sharing information.

13.13.62 The meeting documented that a safety plan was in place and that Children's Social Care was completing a single assessment. The actions from the MARAC were shared with Liverpool Women's Hospital on 21

December. There were a number of agencies who were not invited to the meeting or approached for information. This is covered in Term 14. The Review Panel was informed that actions from MARAC are now sent out within a week of the meeting.

13.13.63 On 6 November, Koffi's support worker spoke with him about the incident on 6 October. Koffi stated that during contact with the police, Tay had given them a wrong surname and date of birth for him, which has been confirmed during the completion of the DHR and murder investigation. The support worker spoke to Koffi about the incident and advised him against further matters. He replied: 'I will never touch her again and was only trying to protect the baby'.

13.13.64 On 11 November, Tay and Marley were seen by a health visitor. The visit took place at Koffi's accommodation. Tay had told the health visitor that she had been staying with family for a 'break' and agreed to go back to Koffi's accommodation for the visit to take place.

13.13.65 On 19 November, Tay, Koffi, and Marley were seen by a GP. This was a follow-up appointment with Tay, following the birth of Marley. The GP Practice was not aware of the domestic abuse incident on 6 October.

13.13.66 At the beginning of December, Koffi's support worker began to contact professionals in order to provide character statements to support Koffi's asylum application. This included contact with his college and church.

13.13.67 On 10 December, the health visitor telephoned the social worker completing the single assessment and was informed that the case was to be stepped down to Early Help.

13.13.68 During this contact, it was identified that it was the first time that Koffi's vulnerabilities as an unaccompanied asylum- seeking child were recorded in Marley's health record. The case was stepped down to Early Help on 17 December.

13.13.69 On 15 December, Tay provided a statement to Koffi's solicitor in support of his appeal against his asylum.

13.13.70 On 24 December, Koffi's support worker recorded that Koffi was to be asked to attend a course about his behaviour, and Tay would be asked to attend a mother and baby group. This information came from Koffi's personal advisor.

13.14 **2021**

13.14.1 On 8 January, Tay and Koffi were seen by an Early Help worker. Tay stated that she had secured a new build property and hoped to move in by the end of the month. Tay stated that Koffi would not be moving in with her, but that they would remain a couple, with each having their own house and own space. Koffi stated that he had been coping well lately, that he had support from a personal advisor, that he had been speaking to Talk Liverpool once a week for two hours at a time, and that he was taking his medication and felt that it was working. A further visit was arranged.

13.14.2 On 14 January, during a visit by his support worker, Koffi stated: 'that his partner is annoying him, and she doesn't want him to go out and he does everything in the house as she is very lazy. He complained that she always wants money of him and when he gets his allowance, she always asks me for money. She bring in friends and they drink lots of alcohol with her friends in the house and he is not comfortable with that. Koffi said she tells her mum false stories about him. (She calls me names like a refugee)'.

13.14.3 The support worker advised Koffi that when he gets angry, he should go out and sit in the park or visit a friend and tell the family support worker of his concerns. The support worker relayed the information to Koffi's personal advisor on 18 January.

13.14.4 The above direct voice of Koffi has been included in this section to provide the context of the discussions and Koffi's views.

13.14.5 On 21 January, Koffi, Tay, and Marley attended a visual court hearing as part of the appeal processes for his asylum claim. They were supported in the hearing by Koffi's support worker. Koffi was informed that a decision would be expected in about two weeks. The following day, the support worker received verbal information that Koffi's appeal had been successful, and he had been granted Leave to Remain.

13.14.6 On 27 January, Tay, Koffi, and Marley were seen at Koffi's accommodation by the named health visitor. It was documented that Tay was hoping to get her own flat and had returned to work. Tay reported good relationship with Koffi. There were no concerns regarding Marley's health and development.

13.14.7 On 28 January, Tay attended a viewing of a two-bedroom property, following a successful application via Property Pool Plus. Tay paid a week's rent in advance and arranged a date to collect the keys.

13.14.8 At a later date in January, Tay was found deceased at Koffi's accommodation. Koffi was arrested for the murder of Tay. Marley was found in the accommodation with Tay, where she was taken to hospital for assessment before being placed in the care of Children's Social Care.

14. Analysis using the Terms of Reference

14.1 Term 1

14.1.1 **What knowledge did your agency have regarding Tay and Koffi's housing situation and tenancies?**

14.2 Koffi

14.2.1 In March 2018, Koffi was placed in adult accommodation provided by Bedspace, which was funded by the local authority. Koffi was a Looked after Child, as defined by Section 20 Children Act 1989.

14.2.2 Bedspace was commissioned to provide support to Koffi whilst awaiting an outcome of his Leave to Remain. Bedspace also supported with independent living skills. The Review Panel was informed that Bedspace's contractual arrangements with the local authority was to provide accommodation up to the age of 21. Koffi's was allocated six hours of support from a Bedspace support worker each week.

14.2.3 When Koffi was initially placed with Bedspace, his age had not been ascertained. Following an age assessment in May 2018, it was assessed that Koffi was 15 years old, and he was subsequently placed with foster carers outside of the Liverpool area.

14.2.4 Koffi remained in foster care until September 2018, when he moved to semi-independent living: he remained there until January 2019. Records provided to the Review Panel, detailed that concerns were raised by the residential provider about Koffi's attitude and also his behaviour towards a female member of staff. During this time, Koffi made a complaint about the registered manager of the care provider. The complaint was upheld. The Review Panel has been unable to establish contact with the care provider and have not seen the exact details of these concerns.

14.2.5 In January 2019, Koffi returned to Liverpool and was placed in accommodation provided by Bedspace. Koffi remained a tenant with Bedspace until his arrest for the murder of Tay in January 2021. Between January 2019 and January 2021, Koffi lived at two properties owned by Bedspace.

14.2.6 The Review Panel considered the frequency of moves between foster care and care providers for Koffi and the dynamics of placement disruption[33] and if this reflected in Koffi's presentation and behaviour. The Foster Carer, who looked after Koffi in 2018, was experienced in looking after asylum seeking children and described to the Chair that Koffi was 'aggressive' towards her, usually at times when she was giving him instructions.

[33] Placement disruption is defined as repeated moves among foster care placements, which reflect a pattern of reciprocal alienation and rejection between a child and successive caregivers.

14.2.7 The foster carer stated that Koffi got on well with her partner, and other males in the household, including her extended family. The Review Panel were unable to access information from Koffi's care provider in Manchester. The Review Panel determined that with the lack of available information they were unable to reach a conclusion and sought the view of the panel member from Children's Social Care.

14.2.8 The Review Panel Member from Children's Social Care told the Review Panel that it was noted that within this review there was an observation of the relationship dynamic of the young person and the female foster carer and that this was behaviour that could have been explored in more detail. As a result of this observation, the placement disruption process will be updated to reflect where there are concerns that relate to 'gender' as a motivating factor of the disruption this will be given consideration and addressed with the wider carer group for learning and development.

14.2.9 Following access to the report, the family asked whether there had been any changes to Koffi's care plan, following the termination of the foster carer placement. The Review Panel was informed by Children's Social Care that there was no evidence in Children's Social Care files of relationship differences; therefore, there were no changes to Koffi's care plan.

14.2.10 The review has identified that whilst Koffi's address was known and shared with, and by, professionals, the exact nature of his tenancy, and that he was being provided support by Bedspace, was not widely known. Only Bedspace, Mersey Care, and Children's Social Care were aware of Koffi's tenancy and housing situation, including that Bedspace had been commissioned to provide support to Koffi, who was an asylum seeker and seeking Leave to Remain in the United Kingdom.

14.2.11 The police's knowledge of Koffi and Tay's living arrangements was based on information provided by Tay, in response to the domestic abuse incident. The police were not aware at the time of that incident, that Koffi was

subject of an ongoing asylum application and was in receipt of support provided by Bedspace. This is covered later in Term 9.

14.2.12 The Review Panel discussed agencies' lack of knowledge on Bedspace's involvement and service provision to Koffi. The Review Panel agreed that had agencies made additional enquiries during contact and sought to gather detailed information around Tay's and Koffi's living arrangements, this may have identified the involvement of Bedspace and provided professionals with another opportunity to gather further information to inform decision-making. This has been identified as an area of learning, and a relevant recommendation has been made.

14.3 **Tay**

14.3.1 At the commencement of this review, Tay lived with her family. It was not until March 2020, that the Review Panel was able to establish that Tay was spending time living with Koffi. Koffi was still living in accommodation provided by Bedspace. Whilst it was known by Bedspace and Children's Social Care that Tay was spending time living with Koffi, Tay was never recorded or classed as a tenant.

14.3.2 In May 2020, Tay applied for Property Pool Plus. The application was successful. During the application process and ongoing contact, there was no reference to domestic abuse or that Tay had a partner/boyfriend. Tay was successful in the allocation of a two-bedroomed flat and attended a viewing on 28 January 2021, during which Tay told the housing officer that the move to the flat 'was going to be a fresh start for her and her child'. There was no record that Koffi would be moving into the accommodation.

14.3.3 Following the domestic abuse incident in October, Tay repeatedly told professionals that she intended to move out of the accommodation she was living in with Koffi, into her own accommodation with Marley. The first agency to know this, was the police (on 7 October), when Tay provided an additional statement in relation to the domestic abuse incident.

14.3.4 During contact with an IDVA on 12 October, Tay stated that the property she was living in had a joint tenancy and was privately rented with Koffi. The IDVA discussed options to support Tay in order to secure safe accommodation, should she wish. Tay told the IDVA that she wanted to move from the current property as it only had one bedroom and was too small. The information provided to the IDVA was incorrect, but this was not known by the IDVA.

14.3.5 When the MARAC was held on 5 November 2020, there were no details of Tay and Koffi's housing provider; therefore, no information was requested from Bedspace. During that meeting, neither Children's Social Care nor Mersey Care shared this information: that the accommodation was provided by Bedspace and that Koffi was in receipt of support. This is addressed in Term 10.

14.3.6 Tay told a social worker (as part of the single assessment), an Early Help worker (during contact in January 2021), and a health visitor (in the days prior to her death), that she was making arrangements to move into her own accommodation with Marley.

14.3.7 Women's Aid[34] provides details as to the reasons why women do not leave a relationship but also evidence the risks that are present when they do. In an article titled 'Why don't women leave abusive relationships?'[35], the article details that: 'One of the most important reasons women don't leave is because it can be incredibly dangerous. The fear that women feel is very real – there is a huge rise in the likelihood of violence after separation. 41% (37 of 91) of women killed by a male partner/former partner in England, Wales, and Northern Ireland in 2018 had separated or taken steps to separate from them. Eleven of these 37 women were killed within the first month of separation and 24 were killed within the first year (Femicide Census, 2020)'.

[34] https://www.womensaid.org.uk/
[35] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

14.3.8 The Review Panel agreed that professionals did not fully explore with Tay, her decision to move into her own accommodation, nor did those professionals recognise the potential increase in risk of domestic abuse towards Tay at the time of this decision and subsequent move. This is analysed under Term 2.

14.4 Term 2

14.4.1 **What indicators of domestic abuse, including coercive and controlling behaviour,[36] did your agency identify for Tay?**

14.4.2 Bedspace was not aware of the domestic abuse incident on 6 October 2020, until they were informed by Koffi's personal advisor during a telephone call on 5 November. The purpose of that telephone call was that Koffi had made some comments to his support worker about Tay, and the support worker had agreed to raise these with Koffi's personal advisor. The details of Koffi's comments are documented at 13.13.58.

14.4.3 The full details of the incident in October, including the risk level to Tay and that the case had been referred to MARAC, were not shared during that conversation. Bedspace informed the Review Panel that had they had known of the incident in October, Koffi's risk assessment would have been reviewed and updated as relevant.

14.4.4 On 14 January 2021, Koffi made further comments to his support worker about Tay. During that contact, the support worker advised Koffi that he should go out and sit in the park or visit a friend when he gets angry.

14.4.5 Koffi was advised by the support worker to tell the family support worker (from Early Help) of his concerns about Tay. There was no record that Koffi did tell the family support worker. The support worker shared the comments (made by Koffi) with his personal advisor, four days later. This was the only professional that these comments were shared with. The details of these comments are documented at 13.14.2.

[36] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

14.4.6 None of the comments made by Koffi were recognised as being indicators of domestic abuse. The Review Panel recognised that the comments made by Koffi, could be construed as victim blaming: the panel has included these in the report to aid the context of the review and the information that was known at relevant times. The Review Panel recognised that Tay and Koffi were vulnerable, they had both just turned 18, and whilst classed as adults, they were still young and were adjusting to life, caring for a newborn baby. The Review Panel was clear in their analysis that the comments made by Koffi were misogynistic, and this was a missed opportunity of further exploration by professionals to understand and explore their context to determine any potential risk factors and respond accordingly. This has been identified as an area of learning, and a relevant recommendation has been made.

14.4.7 Both Tay and Marley's, and Koffi's GP Practices were not aware of the domestic abuse incident in October 2020, nor the subsequent MARAC meeting. This resulted in neither GP Practice, sharing information with other agencies and/or seeking to enquire about domestic abuse during contact with the subjects of the review. This has been identified as an area of learning and is covered in Term 10.

14.4.8 Children's Social Care was involved with Koffi as a Looked after Child, and then a subsequent Care Leaver. Children's Social Care was involved with Marley during the completion of a single assessment in response to the domestic abuse incident in October 2020.

14.4.9 There were indicators in Children's Social Care files, of emerging themed behaviours perpetrated by Koffi, which when considered in totality, and with hindsight, were of concern.

14.4.10 These included incidents in a previous foster placement between Koffi and the female foster carer. Records indicated that these incidents were magnified because of the foster carer's gender. The Review Panel was informed by Children's Social Care that these incidents were not isolated and, on the reflection of Children's Social Care during completion of work for this review, there was no record of any action or response to Koffi's behaviour.

14.4.11 Due to the Covid-19 pandemic, Liverpool City Council implemented alternative visiting protocols, which resulted in some interactions with Koffi and Tay being completed by a video call, as opposed to face-to-face meetings.

14.4.12 On 20 October 2020, Koffi's personal advisor visited him at his accommodation. During that visit, Tay remained in the bedroom with Marley. It was documented that Tay was reluctant to come out and speak with the personal advisor.

14.4.13 Whilst this may have been part of Tay's character or based on a simple unwillingness to participate in the discussions, there was a lack of curiosity as to the reasons behind this presentation and if this was linked to the dynamics of Tay and Koffi's relationship. Of concern, was that there was no consideration that this may have been an indicator of coercion and control.

14.4.14 At the time of the visit on 20 October, the personal advisor was not aware of the domestic abuse incident that had occurred on 6 October. Details of the incident were not known by the personal advisor until 30 October. During the practitioner event, Koffi's personal advisor stated that during this contact, Koffi had been 'guarded' about his relationship with Tay.

14.4.15 Six days later, on 6 November, further concerns were raised by Koffi's support worker to the personal advisor; however, this did not result in any review of the presenting factors and wider consideration of domestic abuse. The personal advisor was not aware about the MARAC, the single assessment that was being completed by Children's Social Care, nor that the case had been stepped down to Early Help. This has been identified as an area of learning by Children's Social Care, to improve the overarching joint working arrangement between Early Help and Children's Social Care.

14.4.16 Children's Social Care commenced a single assessment in response to the domestic abuse incident in October 2020. The outcome of the single assessment recommended that the case should progress as a Child in Need,

in accordance with Section 17 Children Act 1989[37]. However, Tay and Koffi did not consent to this approach, which resulted in the case being managed at Early Help. The case was transferred to Early Help at the end of December 2021, with an agreed action plan.

14.4.17 The following indicators of domestic abuse and risks to Tay were identified within the Early Help action plan:

- Tay had reported domestic abuse to the police.
- Tay had stated that she would end the relationship if there was a further incident.
- There had been two incidents of domestic abuse.
- Koffi had depression and was not taking his medication as prescribed.
- Tay was very isolated.
- Due to Marley's age, observations were to take place to gain an insight into her lived experience.

14.4.18. At the point of the case transferring to Early Help, it was documented that Tay and Koffi had stated that they had addressed the issue in respect to Koffi's mental health, and that they both believed the domestic abuse incident was a result of a change in Koffi's medication and the cause of the deterioration in his mental health. Tay and Koffi were reported to have stated that they had the support of a health visitor and Koffi's personal advisor. There was no record that Tay and Koffi's views were explored further.

14.4.19. The IDVA had two telephone contacts with Tay, during which Tay stated that she felt that she was in some way responsible for the domestic abuse incident. The IDVA spoke with Tay about the dynamics of abuse and the tactics and presentation of perpetrators. Tay stated that the domestic abuse incident was the first time this had happened, and that she wanted to be in a relationship but recognised that time apart had allowed her to reflect and focus on her and the baby. Tay stated that her mother was the most

[37] https://www.legislation.gov.uk/ukpga/1989/41/section/17
Section 17 of the Act places a general duty on all local authorities to 'safeguard and promote the welfare of children within their area who are in need.

important support for her, whom she described as being “a great help”. During these contacts, the IDVA identified a number of indicators of domestic abuse, which included:

- Physical abuse
- Isolation
- Pregnancy / recent birth
- Mental health of Koffi
- Mental health of Tay – who disclosed post-natal depression
- Verbal abuse / aggression / name calling / questioning Tay’s parenting ability/skills
- Keeping her against her will.

14.4.20. The Review Panel has seen no other record that Tay had stated that she was suffering with post-natal depression. The Review Panel was keen to explore this further and were informed that as part of Mersey Care Healthy Child contact during birth and follow-up birth visits, Tay’s emotional well-being was recorded as being good and the ‘Whooley Questions’[38] were recorded with answers of ‘no’, which supported indications of good emotional well-being and no evidence of mental health needs at this time. There were no indicators of post-natal depression.

14.4.21. Liverpool Women’s Hospital had no record or indicators of domestic abuse until they received a notification following the incident in October 2020. Prior to this, Tay had been asked a routine enquiry during contact with midwifery services, where it was appropriate to do so – i.e., when she was not in the presence of Koffi. There were no indicators of domestic abuse, coercive control, or areas of concerns raised.

14.4.22. Mersey Care did not hold any information of domestic abuse during their engagement with Koffi.

[38] https://www.nice.org.uk/Media/Default/Standards-and-indicators/QOF%20Indicator%20Key%20documents/NM156%20NICE%20consultation%20report.pdf
The Whooley questions were introduced by the National Institute for Clinical Excellence (NICE 2007) when they reviewed their guidelines for Antenatal and Postnatal Mental Health. You can expect to be asked these questions at regular intervals by health professionals both antenatally and postnatally. The questions are a screening tool, which is designed to try and identify two symptoms that may be present in depression.

14.4.23. Marley did not have a named health visitor because her case was being managed at a universal level of need, which was in line with case management. When the VPRF1 was received by the health visiting team in October 2020, the VPRF1 was reviewed by the duty health visitor, and an enquiry was made to the team leader around allocation. Contact was also made with Children's Social Care. On 26 October 2020, the health visiting service was informed by Children's Social Care that the case was closing, therefore a decision was made that Marley's case would remain with the health visiting team and would be allocated to a named health visitor, if necessary, after further visits or information received. The case was later allocated to a health visitor.

14.4.24. The Review Panel has identified that Koffi's full details were not recorded on Marley's health record. During the practitioner event, a representative from the health visiting team stated that they were not aware that Koffi was a Care Leaver, which explained why there was no record of any contact between the health visiting team and the Child in Care team (who were responsible for Koffi).

14.4.25. On 11 November, a health visitor telephoned Tay to complete a follow-up birth visit[39]. During the telephone call, Tay advised that she was staying with family, and having a 'break', but agreed to return to Koffi's accommodation for the visit to take place. Later that day, a health visitor saw Tay and Marley at Koffi's accommodation. The health visitor was not aware if Koffi was in the accommodation at the time of the visit. The Review Panel was informed that a health visitor did enquire about the relationship between Tay and Koffi during contacts. Tay shared to a health visitor that Koffi was supportive, at both the birth and follow-up birth visit.

14.4.26. Health records did not document if the health visitor had reviewed the VPRF1 prior to the visit and if the VPRF1 was discussed with Tay. During this contact, Tay reported that she was staying with her aunt for a 'break'.

[39] A follow-up birth visit is ordinarily completed between 6-8 weeks following birth. This is expected to be offered as a face-to-face contact.

14.4.27. Tay reported that ‘things were ok’ between her and her partner, but that she and Marley had just been having a ‘break’ with a family member. Whilst this was discussed with the health visitor, the Review Panel agreed that this was an opportunity for further information to have been gathered from Tay, to understand the current situation and risk factors. The Review Panel has identified this as an area of learning and made a relevant recommendation.

14.4.28. The City of Liverpool College was not aware of the domestic abuse incident that had occurred in October. During contact with the Review Chair and Author, Tutor 1 and Tutor 2 stated that the college delivers a programme of personal, social, health and economic (PHSE), which includes knife crime, drugs, healthy relationships / acceptable behaviour in the United Kingdom, and had it known about the domestic abuse, there would have been an opportunity for the college to have addressed this within class settings.

14.4.29. Tutor 1 and Tutor 2 told the Review Chair and Author that they were shocked when they learnt that Koffi had an English girlfriend. The college was not aware of Koffi’s relationship until he returned to the college in September 2020, after the national lockdown due to the Covid-19 pandemic. The Review Chair and Author were told that Koffi had a number of conversations with staff after this time, in which he described Tay as difficult and that she was demanding money. Koffi had stated that Tay did not like him going out and that she would manufacture an argument to stop him leaving the flat. The Review Panel recognised that the comments of Koffi can be seen as victim blaming but have included them within the analysis to document the information that was known at that time and Koffi’s description of his relationship with Tay.

14.4.30. Tutor 1 and Tutor 2 told the Review Chair and Author that they put these comments down to the stress of a young couple, during Tay’s pregnancy and following the birth of Marley. The comments were not considered to be indicators of domestic abuse. Tutor 1 and Tutor 2 stated that they knew that Koffi had a support worker from Bedspace and therefore did not consider referrals to other agencies.

14.4.31. The Review Panel also identified that the college was not familiar with domestic abuse processes in Liverpool, including the role and remit of MARAC. The college held information that was not captured or gathered as part of information sharing processes to inform risk factors and MARAC. The Review Panel has identified this as an area of learning and made a relevant recommendation.

14.4.32. Tay provided clear indicators of domestic abuse, including coercive control, during her contact with the police in October 2020. These indicators included verbal aggression during pregnancy, a deteriorating situation following Marley's birth, and Koffi physically preventing her from leaving the flat during the incident on 6 October. The VPRF1 identified that Koffi had mental health issues and that he was doubling up on his prescribed medication for depression because he thought his medication was ineffective. Tay cited this self-medication as the cause of Koffi's aggression and violence towards her on two consecutive days: those being the day she contacted the police and an incident the previous day when Koffi had grabbed her arm. Tay told the police that there was an escalation in Koffi's behaviour.

14.4.33. Tay provided a statement to the police and photographs of the injuries that she had sustained. Koffi was not at the accommodation when the police arrived. Attempts to find Koffi were unsuccessful, and he was circulated as a wanted person on the Police National Computer.

14.4.34. Tay's statement recorded that she had been assaulted by Koffi on two separate occasions: on 5 and 6 October 2020. During the latter incident, Tay had been making attempts to leave the accommodation with Marley, to stay in a hotel for the night. Tay had wanted to leave the accommodation as she feared that Koffi would assault her again, as he had done the previous day. Tay described in her statement, how she had run into the bathroom, at which point, Koffi had shut the door and prevented her from leaving. Tay had then started to shout for help, at which point Koffi had put his hand over her mouth, and fingers down her throat, to stop her shouting.

14.4.35. The risk to Tay was initially assessed as bronze, by the attending police officers; however, following a review, the risk was increased to gold and referred to MARAC. During contact with the police on 7 October, Tay stated that she no longer supported a prosecution. There was no evidence as to whether this decision was made due to coercion and control perpetrated by Koffi. The police closed their case. Koffi had not been seen. This is analysed further under Term 9.

14.4.36. In considering the collective information held by agencies, the Review Panel was unanimous in their decisions that Tay had been the victim of domestic abuse and coercive and controlling behaviour, perpetrated by Koffi.

14.4.37. The Review Panel reflected on the identified areas of risk towards Tay, and in particular, the elements of this case that increased the risk. It was clear to the Review Panel that the deterioration of Koffi's mental health and his self-medication to respond to the deterioration, would have had an impact on his presentation and behaviour; however, the Review Panel was clear in their views that these facts should not be seen as an excuse for the abuse he perpetrated towards Tay.

14.4.38. The Review Panel's Equality and Diversity panel member stated that cultural and religious issues should be taken into account during every contact, and that professionals need to be mindful that they do not stereotype individuals. In particular, whilst someone may have a particular culture or religion, it should not be assumed that any behaviour that they display is due to their culture and/or religion.

14.4.39. The Review Panel identified the following indicators of domestic abuse, coercion and control, and areas of risk:

- Separation
- Tay moving out of accommodation
- Newborn baby
- Mental health
- Adverse childhood experiences of Koffi

- Isolation
- Impact of Covid-19 restrictions, including Tay being vulnerable and having to shield
- Coercive control
- Preventing Tay to leave the property
- Physical abuse.

14.4.40. The Review Panel agreed that these areas of risk had not been fully considered during contact with professionals. This has been identified as an area of learning, and a relevant recommendation has been made.

14.4.41. Domestic homicides didn't appear to increase dramatically during the pandemic – with 163 recorded in the 12 months to 31 March 2021. This was very similar to the previous year's figure of 152 and is in line with the 15-year average, according to the Domestic Homicide Project, Vulnerability Knowledge, and Practice Programme (VKPP), NPCC, College of Policing.

14.4.42. The Project found that COVID-19 acted as an 'escalator and intensifier of existing abuse' in some instances, with victims less able to seek help due to COVID-19 restrictions. It also concluded that COVID-19 had not 'caused' domestic homicide, but it had been 'weaponised' by some abusers, as both a new tool of control over victims and – in some cases – as an excuse or defence for abuse or homicide of the victim.

14.5. **Term 3**

14.5.1 **How did your agency assess the level of risk faced by Tay from the alleged perpetrator, and which risk assessment model did you use?**

14.5.2 Merseyside Police utilise the MeRIT risk assessment tool to quantify risk in domestic incidents. The police were the only agency to complete a domestic abuse risk assessment on this case. The initial risk assessment, by the attending police officer for the incident in October 2020, was bronze. The secondary risk assessment at the MASH, provided a silver grade; however, given the circumstances and the perceived risk to Tay and Marley, the

incident was referred to a supervisor who reviewed the risk and upgraded it to gold. The case was referred to MARAC and IDVA. Further analysis on the supervision and management is covered in Term 11.

14.5.3 The IMR author for the police has highlighted that within the VPRF1 and statement provided by Tay, it was recorded that Tay had stated that Koffi had stopped her raising the alarm by forcing his fingers down her throat for about seven seconds, making it difficult for her to breathe. The police incident log was endorsed by the attending officer that the case had been discussed with the domestic abuse (DA) sergeant, who ensured the question set and VPRF1 had been completed, and after completion, they authorised the closure of the incident log.

14.5.4 Following the first risk assessment at the MASH, it was recorded that no mental health issues had been identified; therefore, a referral to adult services was not deemed necessary. However, this was inaccurate as it was clear within the VPRF1 that Koffi was struggling to manage his depression with his prescribed medication, and that this had caused him to be aggressive and violent, thereby putting Tay and Marley at risk.

14.5.5 Following the murder of Tay, Merseyside Police reviewed their response to this incident and identified areas of learning, which have been included within Term 14.

14.5.6 The IDVA supported Tay and used the information in the VPRF1, which includes the MeRIT, to review and assess risk. During initial contact with Tay, the IDVA discussed risk indicators and risk factors, which included: general safety; housing; finances; health, including mental health and health of Marley; emotional impact; and support already in place, which included support from family and friends.

14.5.7 On 15 October 2020, Children's Social Care received a referral in response to the incident on 6 October. A single assessment was completed, which concluded on 11 December. Within the assessment, it noted that domestic abuse was likely to have a detrimental impact on the child's development, with

relevant research attributed to this entry. However, the Review Panel has been informed that this research related to specific tools and assessment models to quantify or grade risk, rather than supportive evidence of the impact on children who are victims of domestic abuse.

14.5.8 The following record documents the information gathered and considered by Early Help in December 2020, in developing their plan:

14.5.8.1 **Background information / reason for assessment / allocation plan**

- Koffi had been a Looked After Child from March 2018 to October 2020.
- Koffi continued to be supported by a personal advisor, support worker from Bedspace, and advocate.
- Koffi was an unaccompanied asylum seeker from the Ivory Coast. Koffi's parents were deceased. Koffi fled his homeland for fear of being killed. Koffi said that he had been assaulted by soldiers and police officers.
- Tay had not had Children's Social Care involvement.
- Tay had described that she had witnessed domestic abuse as a child, and that her parents were separated.

14.5.8.2 **The allocation plan was as follows:**

14.5.8.3 What's working well?

- Marley's basic care needs are met by her parents.
- Parents are emotionally warm and affectionate with Marley.
- Koffi is taking his medication appropriately.
- Koffi is accessing support via Talk Liverpool.
- Koffi is supported by Liverpool City Council and has a personal advisor.
- Tay called the police when Koffi became abusive.
- Parents engage well with health services.
- Tay has said that if there is a further incident, she will end the relationship.

14.5.8.4 What are we worried about?

- There have been two incidents of domestic abuse.

- Koffi has depression and was not taking his medication as prescribed.

14.5.8.5. Step down actions:

- Koffi needs to take his medication as prescribed and have his medication reviewed if he feels that the medication is not working.
- Tay is very isolated; she will access support via Children's Centre.
- Koffi to access support re: parenting, via the Children's Centre.
- Koffi to access support re: domestic abuse.

14.5.8.6. Actions identified:

- Undertake a visit to the family if they are not contactable via phone.
- Please contact health visitor again if she has not made contact with outreach family support worker.
- Please arrange a Team Around the Family meeting within 10 working days.
- Please discuss with parents, completing a Graded Care Profile 2 GCP2 (assessment tool)[40].
- Please signpost mother to South Liverpool Domestic Abuse Services (SLDAS)[41], to provide emotional support.
- Due to baby's age, please complete observations to gain an insight into her lived experience.
- Support and advice around housing – possible referral to Creative Support. Tay is bidding, but to see what else can be done to support them with the housing situation.

14.5.9. In response to the action plan, contact was attempted with Tay and Koffi on three occasions – between 21 December 2020 and 28 December 2020. No response was received to these contacts, and a voicemail was left. On 29 December, contact was made with Koffi, via telephone, and he agreed to provide a date for a home visit. An initial visit was undertaken on 8 January 2021, during which it was agreed with Tay and Koffi that they would be seen

[40] https://learning.nspcc.org.uk/research-resources/2022/graded-care-profile-2-case-study-evaluation/
[41] https://sldas.org.uk/

fortnightly, with calls and texts in between until Tay had moved into her new home.

14.5.10. On 13 January, Tay cancelled an appointment with an outreach worker, citing that she was busy preparing to move out of Koffi's accommodation. A further visit was arranged for 21 January; however, there was no record that this took place.

14.5.11. The Review Panel reflected on the agreed action plan and concluded that there were areas of work that had been identified to support and respond to the risk. The case had been allocated to Early Help towards the end of December, and at the time of Tay's murder, there were a significant number of actions, of which there was no record as to whether they had been progressed. These included no record that the Team around the Family meeting had taken place: this was actioned to have taken place within 10 days. There was no documented entries of telephone and text message contacts in between the fortnightly visits.

14.5.12. There were inaccuracies in the plan, which included the fact that Koffi was no longer in contact with Talk Liverpool, as this had ended on 4 November 2020.

14.5.13. The Review Panel discussed the action plan and determined that the information had been gathered and accepted without challenge or verification. The Review Panel agreed that there was learning for Children's Social Care in relation to the co-ordination, supervision, and management of Early Help action plans, and the panel has made a relevant recommendation.

14.6. **Term 4**

14.6.8. **What services did your agency provide for Tay and/or Koffi; were they timely, proportionate, and 'fit for purpose', in relation to the identified levels of risk?**

14.6.9. Koffi was allocated six hours of support per week, with a support worker at Bedspace. This is covered within Term 1.

14.6.10. Children's Social Care supported Koffi as a Looked after Child; in that he was an unaccompanied asylum-seeking child following an age assessment. Koffi was given support in relation to accessing education, training, and employment, as well as accommodation and financial support.

14.6.11. When Koffi turned 18, he received support as a Care Leaver and had a personal advisor. During the practitioner event, Koffi's personal advisor stated that they had only met Koffi, in person, on one occasion – with other contact being undertaken via telephone and video calls. The contact methods were restricted to telephone and video calls due to the Covid-19 pandemic.

14.6.12. It was noted within Children's Social Care records, that Koffi had reported that he had been struggling financially; however, the financial support did not increase and was maintained in line with the local agreed financial support for Care Leavers (aligned to Universal Credit).

14.6.13. The Review Panel discussed Koffi's financial situation, and whether there was any reference to this in other agencies records, including any documented account of this impacting on his relationship with Tay. The Review Panel sought clarification on this matter – as they are aware that financial abuse is an indicator of domestic abuse and an aspect of coercive control, and that financial abuse involves similar behaviours to economic abuse. Surviving Economic Abuse[42] (a UK charity) provides detailed information, which the Review Panel considered against the information gathered on this case, to help inform the panel's discussions. The Review Panel did not identify that Tay was a victim of financial and/or economic abuse from Koffi.

14.6.14. Children's Social Care completed a single assessment following the domestic abuse incident. The recommended outcome was for the case to

[42] https://survivingeconomicabuse.org/what-is-economic-abuse/

be managed at Child in Need. For this to take place, Tay and Koffi needed to provide their consent, which neither did. There was no evidence on the information provided that would have allowed for the case to have been stepped up to child protection processes, in accordance with Section 47 Children Act 1989[43]. The case was stepped down to Early Help. Further analysis on this is covered in Term 3.

14.6.15. The Review Panel agreed that the most appropriate response and management of the case would have been at Child in Need. In reaching this decision, the Review Panel determined that the outcome of the single assessment had been based on inaccurate information. There was no evidence that the information that had been provided by Tay and Koffi, had been checked and verified – i.e., Koffi's engagement with Talk Liverpool.

14.6.16. The Review Panel agreed that as Tay and Koffi had not provided their consent for the case to be managed at Child in Need level, this did not mean that there were not any concerns present. The Review Panel agreed that the case identified learning around professionals being proactive in checking/verifying information and challenging where there are identified inaccuracies. This has been identified as an area of learning, and a relevant recommendation has been made.

14.6.17. Tay was referred to the IDVA service during October and November. Their contact was in line with their policies and processes, which are victim led.

14.6.18. Tay and Marley were initially supported by Health, at a universal level of need; however, in November 2020, when it was identified that the case was to remain open and be managed by the Early Health and Assessment Team, they were then allocated a named health visitor. Tay and Marley were initially supported by Health, at a universal level of need; however, in November 2020, when it was identified that the case was to remain open

[43] https://www.legislation.gov.uk/ukpga/1989/41/section/47
Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare.

and be managed by the Early Health and Assessment Team, they were then allocated a named health visitor. The Review Panel reflected on the circumstances of the case, and the information that was available to professionals, had relevant enquiries been made and questions asked – including Koffi's adverse childhood experiences, his immigration status, etc. The panel also reflected on whether the case would have identified an additional level of need, following the birth of Marley. The Review Panel agreed that had professionals gathered further background in relation to home and living arrangements, this would have provided an opportunity for an overarching view of Tay and Koffi's relationship and living arrangements. It would have also allowed for the identification of other agencies and professionals' involvement. This has been identified as an area of learning, and a relevant recommendation has been made.

14.6.19. When Koffi moved back to Liverpool in January 2019, there was a delay in Koffi being allocated to Mersey Care child health services. This did not take place until July 2019. The reason for this was unclear. The Review Panel was informed that Child in Care services in Mersey Care, have since been reviewed and strengthened to support timely allocation of cases, which has negated the need for a recommendation.

14.6.20. Koffi had two periods of contact with Talk Liverpool: for low mood and symptoms of trauma. Koffi was offered appointments for assessment, which were followed up with offers of contact and engagement. Talk Liverpool experienced difficulties in initially contacting Koffi in 2020: these were due to changes in contact details, followed by, on one occasion, the unavailability of an interpreter, and then a cancellation due to sickness.

14.6.21. Between 23 September and 4 November 2020, Koffi attended seven weekly sessions with a psychological well-being practitioner. These sessions took place via Language Line. The focus of the sessions was behavioural activation for depression and risk management. During the sessions, Koffi reported thoughts to harm self, with no intent or plans elicited. Koffi reported one historic episode of deliberate self-harm, by cutting himself with

a knife. A risk management plan was agreed at the end of each session. No risk to others were elicited. Koffi reported having a girlfriend and newborn child, and that he was seeking asylum. Depression, anxiety, and risk assessments were completed at each session, and risk management plans were agreed.

14.6.22. Talk Liverpool was not aware of the domestic abuse incident that had occurred in October 2020. The professionals who had worked with Koffi, stated during the practitioner event, that had they known about the domestic abuse incident, then they would have addressed this during their contact, reviewed their risk assessment, and would have been able to have provided information to inform the MARAC. This has been identified as a single area of learning.

14.7. **Term 5**

14.7.8. **Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?**

14.7.9. Koffi was supported with aspects of independent living and was advised of his options and choices by Bedspace.

14.7.10. On 24 December 2020, Koffi's personal advisor informed his support worker that Koffi would be asked to attend a course about his behaviour, and that Tay would be asked to attend a mother and baby group: these invites would be relayed to them by the social worker. It was documented in Bedspace records that this was an action from the MARAC; however, this was incorrect and would have appeared to have been part of the Early Help plan.

14.7.11. Marley's health records did not document that Tay was given advice regarding domestic abuse support. The Review Panel was informed that during each contact with a health visitor, there were no indicators of concerns within Tay and Koffi's relationship. Tay shared what support she had and stated that everything was 'ok'.

14.7.12. Talk Liverpool discussed the outcome of their assessment and treatment options with Koffi. Letters were also sent to Koffi, detailing the treatment plan agreed. An interpreter was also present during assessment and therapy sessions, via Language Line, to ensure Koffi was in receipt of an appropriate standard of needs assessment and subsequent treatment plan. The review established that the letters that detailed the agreed treatment plan, were sent in English. Whilst the Review Panel has not seen any evidence that Koffi had indicated to professionals that he was unable to read the letters, the Review Panel agreed that as it was known that English was not Koffi's first language, and as his engagement during assessments and therapy sessions had been assisted with an interpreter, then it would have been good practice for the letter to have been sent in the language in which Koffi could read and understand. The Review Panel has identified this as an area of learning and made a relevant recommendation.

14.7.13. As part of his safety plan, Koffi was signposted to mental health crisis services by Talk Liverpool. These services offer support for people out of hours or when emergency mental health advice is required.

14.7.14. Koffi was not spoken to by the police about the domestic abuse in October 2020. As detailed within Term 9, the only professional to speak with Koffi, was his support worker.

14.7.15. The police spoke with Tay on several occasions. It was documented by the police that during contact on 15 October, Tay expressed her concern at receiving daily telephone calls and messages about the incident, despite her decision not to support a prosecution. Tay told the officer who had contacted her on this day, that she wanted to put the matter behind her and concentrate on Marley.

14.7.16. The Review Panel reflected on the comment made by Tay and agreed that given Tay's age, and that she had recently given birth to Marley, it was understandable that she may have found the contact from professionals overwhelming. The Review Panel also discussed that a lot of contact with

Tay during this time, would have been in relation to the birth of Marley as well as the domestic abuse incident, and that this would have taken place via telephone, due to restrictions in place because of the Covid-19 pandemic. These restrictions would have prevented professionals knowing the whereabouts of Koffi and what influence he had on Tay's engagement with professionals.

14.7.17. The Early Help action plan had identified services to support Tay and Koffi. As detailed at Term 3, this action plan was in its infancy at the time of Tay's murder, and the work to address all identified actions had not taken place.

14.8. **Term 6**

14.8.1. **How did your agency ascertain the wishes and feelings of Tay and Koffi regarding Tay's victimisation and Koffi's alleged offending, and were their views considered when providing services or support?**

14.8.2. It was clear to the Review Panel that Koffi's asylum application and appeal process had a significant impact on him. The Review Panel determined that practitioners who were engaged with Tay and Koffi, did not fully understand the impact that this had on Koffi, nor on them as a family.

14.8.3. The Review Panel discussed Tay's involvement in Koffi's asylum appeal process. The Review Panel was informed that Tay was asked to provide a statement in support of Koffi's application to remain. It was unclear, from information provided to the review, if Tay's statement was taken in the presence of Koffi. The Review Panel agreed that had this been the situation, then it placed Tay in a difficult situation, in that she would have been providing a statement in the presence of Koffi, who had recently assaulted her, and whom she was planning on leaving and moving into alternative accommodation. The Review Panel concluded that had this taken place, it was not appropriate. Whilst it may have been that Tay did support Koffi's appeal to remain, the Review Panel was clear in their conclusions that any information gathered from Tay, should have been obtained alone – to allow her to express her views without any fear of repercussions. The Review

Panel was informed that the solicitor who had represented Koffi and recorded the statement, was no longer in practice.

14.8.4. There were two occasions when Koffi spoke to his support worker about his views and feelings around Tay. These views, which are detailed in Section 13, are negative and victim blaming. The Review Panel agreed that further exploration should have taken place with Koffi – to understand these comments and to determine if these identified further incidents of domestic abuse.

14.8.5. The Review Panel was informed that Bedspace supports around 250 young people and families.

14.8.6. The Review Panel was also informed that at the time of this case, it was not current practice for support workers to receive training on domestic abuse. Since this case, work has commenced around the sourcing and delivery of appropriate training. The Review Panel acknowledged that this area of learning was being addressed; however, the panel has made a recommendation for Bedspace to provide timely updates on their action plan to address this area of learning.

14.8.7. The single assessment completed by Children's Social Care, at the end of 2020, considered domestic abuse as a key concern; however, the assessment concluded that it was not considered to be an enduring safeguarding issue for Marley. It was documented that Marley's basic care needs were met, and Tay was reported to demonstrate a good understanding of the impact of domestic abuse on children.

14.8.8. The Review Panel was unanimous in their conclusion that the children are victims of domestic abuse, and that this does not just relate to incidents they have seen and/or heard – as the impact of domestic abuse is far reaching. Whilst Tay may have demonstrated to the social worker an understanding of domestic abuse, Marley was a young child who was non-mobile and nonverbal; therefore, she would not have been able to express

her wishes and feelings. The Review Panel took account of the following research during their discussions on this area.

14.8.9. Women's Aid[44] details the following research findings:

- One in seven (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood.
- 61.7% of women in refuge on the Day to Count 2017 had children (aged under 18) with them (Women's Aid, 2018 – data from Women's Aid Annual Survey 2017).
- Between January 2005 and August 2015 (inclusive) 19 children and two women were killed by perpetrators of domestic abuse in circumstances relating to child contact (formally or informally arranged) (Women's Aid, 2016). A Women's Aid review of SCRs published since August 2015 highlighted at least one more case falling into this category (Women's Aid, 2017).
- Research published by Cafcass in 2017, in partnership with Women's Aid, analysed a sample of 216 child contact cases that closed to Cafcass between April 2015 and March 2016. It found that more than two thirds of the cases in the sample involved allegations of domestic abuse, yet in 23% of these cases, unsupervised contact was ordered at the first hearing.
- Research published by Women's Aid and Queen Mary University London in 2018, based on the experiences of 72 women survivors of domestic abuse whose family court case concluded the last five years, found evidence of gender discrimination and a culture of disbelief within the family courts system. The systemic nature of negative perceptions around survivors of domestic abuse and mothers who raise concerns about child contact arrangements, along with gaps and inconsistencies in understanding and awareness of domestic abuse and its impact on children, is blocking the effectiveness of policies and practices to ensure safe child contact and increase awareness of

[44] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/

domestic abuse within child contact procedures. The ingrained nature of such perceptions also increases the likelihood of human rights protection gaps for survivors and their children (Birchall and Choudhry, 2018).

- In the above research by Women's Aid and Queen Mary University London, 61% of survey respondents had not had any special measures in the family court, 48% said that a fact-finding hearing had not taken place as part of their case, and 24% had been cross-examined by their abusive ex-partner in the court.

14.8.10. In 2015, the Royal College of Psychiatrists published a leaflet[45]: 'Domestic violence and abuse – the impact on children and adolescents.' The leaflet is aimed towards parents and carers. It covers the effects that domestic violence and abuse can have on children, and how to try and avoid these problems. The leaflet states:

14.8.10.1. 'Younger children may become anxious. They may complain of tummy-aches or start to wet their bed. They may find it difficult to sleep, have temper tantrums and start to behave as if they are much younger than they are. They may also find it difficult to separate from their abused parent when they start nursery or school.

14.8.10.2. 'Girls are more likely to keep their distress inside. They may become withdrawn from other people and become anxious or depressed. They may think badly of themselves and complain of vague physical symptoms. They are more likely to have an eating disorder, or to harm themselves by taking overdoses or cutting themselves. They are also more likely to choose an abusive partner themselves.

14.8.10.3. 'Children of any age can develop symptoms of what is called 'Post-traumatic Stress Disorder'. They may get nightmares, flashbacks, become very jumpy, and have headaches and physical pains.

[45] https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children

14.8.11. In 2019, Cafcass Cymru published a report: 'Impact On Children Of Experiencing Domestic Abuse'[46]. The document states: 'Children's responses to living with domestic abuse may vary according to age and stage of development.

14.8.12. The ways in which children are affected may differ. For example, babies living with domestic violence appear to be subject to higher levels of ill health, poorer sleeping habits and excessive crying, along with disrupted attachment patterns. Children of pre-school age tend to be the age group who show most behavioural disturbance such as bed wetting, sleep disturbances and eating difficulties and are particularly vulnerable to blaming themselves for the adult violence. Older children are more likely to show the effects of the disruption in their lives through under performance at school, poorly developed social networks, self-harm, running away and engagement in anti-social behaviour. (Humphreys and Houghton, 2008)'.[47]

14.8.13. The report details further research by Enlow et al, 2012[48], which found that exposure to domestic abuse, particularly in the first two years of life, appears to be especially harmful and that whilst children are pre-programmed to respond to stressful situations, such as hunger, meeting new people, or dealing with new experiences, it is clear that some stressors are more harmful than others. The strong and prolonged activation of the individual child's stress management system results in toxic stress.

14.8.14. During contact with an IDVA, Tay stated that Koffi's mental health issues impacted on his behaviour and resulted in the incident in October 2020. The IDVA discussed with Tay, the dynamics of domestic abuse, including power and control and perpetrator behaviours, and that mental

[46] https://gov.wales/sites/default/files/publications/2019-08/cafcass-cymru-impact-on%20children-experiencing-domestic-abuse.pdf

[47] https://dera.ioe.ac.uk/9525/1/0064117.pdf
Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse – Directions for Good Practice

[48] Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study https://pubmed.ncbi.nlm.nih.gov/22493459/

health is not an excuse and a reason for domestic abuse. The Review Panel agreed with the response of the IDVA.

14.8.15. Koffi's wishes and feelings were obtained directly within his statutory health assessments – completed whilst he was a Looked after Child. There is no record of any discussions around his offending behaviour, which can be attributed to the fact that six days after the incident, he was no longer a Looked after Child and in contact with Mersey Care, although he would have still been supported by the school nursing service.

14.8.16. The police obtained Tay's views during face-to-face contact following the assault and within the statements that she provided. These documents have been shared with the Review Panel. Within Tay's second statement, in which she chooses to not support a prosecution, it is documented that Tay stated: 'I have just had a baby and I feel all that I need to do is to talk about how I am feeling to my midwife and continue talking to my mum for support. The thought of continuing with this case makes me feel even worse and gives me anxiety. It would be too much for me to cope with and I just want to concentrate on my baby. I have put a deposit on a new property and intend on moving there alone. Koffi will stay at our current house. I am unsure if we will continue to be in a relationship, but he is a good dad and has helped out a lot'.

14.8.17. The Review Panel discussed the information that Tay had provided in this statement. The panel was clear in its views that Tay was overwhelmed by her current situation – both as a new mother (with all the challenges that this can bring), as well as having been assaulted and subjected to verbal abuse from Koffi (within the last couple of days). The Review Panel also reflected on the research included throughout the report which supported that Tay's age, sex and other vulnerabilities may have impacted her contact and engagement with agencies.

14.8.18. The Review Panel considered what further support could have been provided to Tay at this time, and by whom, to help her with her current situation. The Review Panel recognised that due to the Covid-19 pandemic,

some services were intermittently closed, including Children's Centres: these would have been an appropriate place for Tay and Marley to have been signposted. Tay was involved with an IDVA, Children's Social Care was undertaking a single assessment, and the case had been heard at MARAC. However, the Review Panel agreed that the restrictions and closures of services at this time, prevented Tay being signposted to other non-statutory services for support.

14.9. **Term 7**

14.9.1. **How effective was inter-agency information sharing and co-operation in response to Tay and Koffi, and was information shared with those agencies who needed it?**

14.9.2. The Review Panel has identified areas of learning at a strategic level for all agencies involved in this review, in relation to inter-agency information sharing.

14.9.3. Bedspace held a significant amount of information on Tay and Koffi's relationship, yet their involvement and ability to support and contribute to inter-agency working was not recognised following the domestic abuse incident and subsequent MARAC meeting.

14.9.4. Neither Tay nor Koffi's GP Practices were informed of the domestic abuse incident. They were not asked to provide information to the MARAC, nor were they informed that a MARAC had been held. Koffi's GP Practice held significant information in relation to his medication and presentations during contact with a GP. This is detailed in Section 11.

14.9.5. The Review Panel held a detailed discussion regarding the MARAC. The Review Panel was informed that, on average, there are 80 cases discussed at each MARAC, with MARACs being held over two days every two weeks (unless there are a large number of cases, and an additional day is held). The Review Panel was informed that attendance of individual health organisations and Trusts covering the Liverpool area, is determined by their individual involvement and therefore there is no single representative on the

MARAC covering all health providers across Liverpool. The Review Panel was also informed that there has been no Education representative for over two years.

14.9.6. The Review Panel was informed that the MARAC Steering Group has raised the issue over MARAC attendance, but there has been limited improvement. This matter has now been escalated. A new IT system is being introduced that will improve communication and information sharing, as well as a pilot of 'face-to-face' MARAC meetings. The Review Panel agreed that there was learning, at a strategic level, from this case regarding the MARAC processes across Liverpool and have made a relevant recommendation.

14.9.7. Tay and Marley were in contact with their GP Practice. There had been several missed telephone calls to Tay and Koffi, and on occasion, when Marley was not brought for immunisations. Had the information (around the domestic abuse) been known to the GP Practice, it would have provided an opportunity for exploration around the missed contacts and to utilise 'routine' enquiry with Tay. The Review Panel has been informed that the GP Practice is devising a policy in relation to children who are not brought or who do not attend appointments. Further learning was identified by the GP Practice following the completion of the Significant Event Analysis – around the documentation of recording details of individuals spoken to during contact, as opposed to entries such as 'mum' 'dad'. This latter area of learning has been addressed through internal communications.

14.9.8. During the completion of this DHR, the Review Panel was informed about work that has been undertaken by Liverpool IDVA service, working in conjunction with GP Practices:

14.9.8.1. **Aims & Objectives**

- Liverpool IDVA service created a training package for all GP staff (within the identified hot spot target areas) to enable them to recognise signs of domestic abuse, encourage disclosure, and raise awareness of support

available. Identifying champions, within each practice, who will receive additional support and training.

- Support general practice staff to have clear pathways to access specialist services and support, we offer training to nominated champions within the practices we work with.
- Provide a service that encourages safe/appropriate information sharing between services who are supporting mutual clients impacted by domestic abuse, including providing MARAC updates.
- Encourage professional curiosity, routine and targeted enquiry throughout practices.
- Identify a named domestic abuse specialist worker who will be a point of contact for GP Practices where there are concerns for a patient. We will provide a central point to provide advice, support, guidance to anyone who is impacted by domestic abuse, and provide signposting to the most appropriate service to provide ongoing support.
- Provide initial safety advice/support to individuals who we recognise as being at risk of domestic abuse.

14.9.8.2. **Outcomes Achieved**

- Trained over 150 staff, including GPs – domestic abuse hot spot areas.
- Identified domestic abuse champions who accessed additional and specialist training.
- Provided all practices/medical centres with GP – Domestic Abuse Handbook, as reference point.
- Provided contact details for services/support and identified appropriate referral pathways to services across the city, including services who support males and people who cause harm to others (perpetrators).
- Improved confidence throughout the practices.
- Individuals volunteering to be champions – passionate and motivated domestic abuse champions across all practices, who participated in the project.

- Delivered MERIT and MARAC training to all domestic abuse champions – this is to encourage and improve information sharing and representation.

14.9.9. Children's Social Care identified gaps in information sharing in two areas. The first of these related to services who work with Care Leavers and adults who were not adequately engaged in the assessment processes around Marley.

14.9.10. The second area related to the long-term involvement of Children's Social Care with Koffi – in that there had been multiple practitioners involved, and the handover and passing on of key case knowledge was diluted, which resulted in themed behaviours and issues not being clearly understood. Both these areas of learning have been addressed through single agency recommendations.

14.9.11. City of Liverpool College was not informed about the domestic abuse incident, nor were they approached for information to inform the MARAC. During contact with the Review Chair and Author, the college stated that they have around 200 students, of which approximately 150 are involved with Children's Social Care. The college stated that there are no information sharing pathways in place for the college to receive information around risk, including domestic abuse, with their students who are under the age of 18 or being supported as a Care Leaver.

14.9.12. The Review Panel discussed how information could be shared and was aware that Operation Encompass[49] is embedded between police forces and education establishments across Liverpool; however, this does not extend to higher education. The Review Panel has identified this as an area of learning and made a relevant recommendation.

14.10. **Term 8**

[49] https://www.operationencompass.org/

14.10.1. **What did your agency do to establish the reasons for Koffi's alleged abusive behaviour, and how did it address them?**

14.10.2. Koffi's lived experiences were clearly documented within his Children in Care health records. It was identified that Koffi had experienced significant trauma, and at the point of his Initial Health Assessment, a referral was made to psychological services. However, Koffi then moved out of the Liverpool area. The Initial Health Assessment was completed whilst Koffi was living in Manchester; however, the identified actions were not completed until Koffi returned to live in Liverpool – this was progressed through contact with Talk Liverpool.

14.10.3. In considering the delay in the actions being progressed, the Review Panel learnt that there is a six-week timescale of allocation of a GP when a patient transfers from one health authority to another. There was also a delay from the initial assessment, as the GP was awaiting the outcome of Koffi's age assessment before identifying the most appropriate service. At this point, Koffi had moved to Manchester.

14.10.4. Within Mersey Care child health records, the relationship between Tay and Koffi was not known until 10 December 2020. Koffi's history and known health needs were not shared within Marley's health record, to support professional curiosity, challenge, or intervention.

14.10.5. On 20 April 2020, Mersey Care received information that Koffi had a girlfriend who was 17 years old and pregnant; however, Tay's details were not obtained and shared, which resulted in a link not being made to Koffi's health records. The IMR author from Mersey Care has identified that had Mersey Care known of their relationship – including the health visiting team, following the incident in October 2020 – it would have provided an opportunity for consideration of safeguarding supervision and direction from specialist domestic abuse agencies to have been sought.

14.10.6. There was little support for Koffi from Children's Social Care, in terms of addressing any abusive behaviour. This was briefly considered as part of

the Children's Social Care assessment following the incident in October 2020; however, there was a reliance that there had been no repeated incidents from the point of referral to the step down to Early Help.

14.10.7. Tay disclosed to professionals her concerns about Koffi: that he had been taking double his medication for his mental health issues and that this impacted his behaviour, which she stated had resulted in the incident where she called the police and another incident the previous day. The Review Panel has seen no evidence that there was a review of Koffi's medication, and that the information about Koffi increasing his medication was shared with Talk Liverpool and his GP.

14.10.8. The VPRF1 completed by the police in October 2020, did not record that Koffi was an asylum seeker. Nor did it record Koffi's alternative names: this resulted in previous police records not being reviewed. It also did not prompt the police to consider the sharing of information, in relation to the incident, with agencies involved in Koffi's asylum application.

14.10.9. The Review Panel determined that, collectively, all agencies involved in this review did not consider Koffi's culture, diversity, and background when responding to his abusive behaviour. The Review Panel has identified this as a strategic area of learning for all agencies.

14.11. **Term 9**

14.11.1. **Was there sufficient focus on reducing the impact of Koffi's alleged abusive behaviour towards the victim, by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?**

14.11.2. Koffi had three different police records with Merseyside Police. This was not established until after the murder of Tay. Koffi's initial record was created on 3 February 2018. This record was accompanied by a photograph. The second record was created in response to the 'missing' episode in July 2019. Koffi's date of birth, on this occasion, was that of the date of birth given in the age assessment in May 2019, which resulted in Koffi's date of birth and

surname being different to that of the initial record. These two records were not linked. The last record was recorded in response to the domestic abuse incident in October 2020. On this record, Koffi's date of birth was different to the previous two records; however, his surname was the same as the first record. On each occasion, a new nominal record was created for Koffi, but they were not linked to each other.

14.11.3. Following access to the report, the family questioned the Review Panel as to why there was no link between the United Kingdom Visa and Immigration Service and Merseyside Police, and other national police forces' IT systems.

14.11.4. The family stated that had the police had access to the UKVI IT system, then this would have created an opportunity for the police to have identified that Koffi was an illegal immigrant and would have reduced the risk of the duplication of nominal records held by the police. However, the police only routinely access Visa and Immigration information when people are arrested and taken into custody. Koffi was never arrested and therefore enquiries with UKVI were not made.

14.11.5. The Review Panel discussed the views with the family. The Review Panel acknowledged that the databases stored data for different legal processes, including criminal activity, as well as intelligence; therefore, accessibility to data held by each organisation would need to be governed by relevant legislation to ensure there was no breach of Government Data Protection Regulations. The Review Panel was not aware that this process around information sharing is in place.

14.11.6. The Review Panel did not receive information from United Kingdom Visa and Immigration until after the conclusion of the DHR. [See 5.7]. The information provided was that of a timeline of key events with no analysis against the wider information gathered by the Review Panel. The information provided did identify that the domestic abuse incident in October 2020 was not known by United Kingdom Visa and Immigration and therefore was not considered as part of the immigration hearing held in January 2021. It is

difficult to analyse what difference this may have made on the outcome of the immigration hearing as any analysis would be hypothetical, but the Review Panel agreed that this did raise a query as to the wider gathering and sharing of information across criminal justice agencies for asylum application processes for those individuals residing within the United Kingdom going through application and appeal processes. This has been identified as an area of learning and a relevant recommendation made.

14.11.7. Merseyside Police had one reported incident of domestic abuse. Koffi was not seen in person or spoken to by the police. This decision was made as Tay had provided a statement to the police, which stated that she did not support a prosecution. However, within this statement, Tay stated: 'I can confirm that the information within my original statement is all true. I have been truthful about the facts.' Tay's original statement provided details of domestic abuse and coercive control. (See 14.8.16)

14.11.8. The police had the opportunity to continue with the investigation and interview Koffi. This did not happen, and the case was closed with no further action taking place. Had Koffi been interviewed, this would have been classed as an Evidence Led Prosecution (ELP); however, because Koffi was not interviewed by the police, the case was never presented to the Crown Prosecution Service for advice as to whether to progress through a criminal route. An interview with Koffi was the only element of the evidence file preventing this from being done, as the police had a statement of complaint from Tay, a further statement not supporting a prosecution, Body Worn Video (BWV) footage of Tay's account, hearsay evidence from the attending police officers, and photographs of Tay's injuries.

14.11.9. Had the police progressed an ELP and sought the advice of a Police Decision Maker (PDM) or the Crown Prosecution Service, a range of options would have been available, such as an Adult Caution, Domestic Violence

Protection Notice/Domestic Violence Protection Order[50] (DVP0/DVPN), or conditional bail to allow further enquiries to have taken place.

14.11.10. A DVPN is an emergency non-molestation and eviction notice that can be issued by the police to a perpetrator (when the police are attending to a domestic abuse incident). Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support, they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application (by the police to a magistrates' court) for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options, with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

14.11.11. The Review Panel was informed that the lack of focus on pursuing an ELP had been identified in a previous domestic homicide in Liverpool (in 2016). The police have identified their response to the incident in October 2020 as a missed opportunity and an area of single agency learning.

14.11.12. Merseyside Police informed the Review Panel that following the death of Tay, the Force has published an Investigations Newsletter, which was circulated to all officers and staff. The newsletter addressed all points by including a case study of certain incidents, highlighting examples when the victim did not support a prosecution but other evidence, such as hearsay statements and Body Worn Video, was available. The newsletter contained a recommendation that officers should investigate domestic abuse proactively from the outset, with a view to building an ELP whenever the support of the victim was absent or when they were in such fear as to be unable to give evidence. Analysis of the key points to prove, and links to legislation, were

[50] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

included. Further impact on this area of learning is covered in Term of Reference 14.

14.11.13. The support worker spoke to Koffi after they became aware of the domestic abuse incident in October 2020. It was documented in Bedspace records that the support worker told Koffi that his actions amounted to assault and were not acceptable behaviour. The support worker was the only professional who had spoken to Koffi directly about the domestic abuse incident; therefore, this was the only recourse he had been given for the incident. The support worker was not aware that Koffi had not been seen or spoken to by the police.

14.11.14. Bedspace informed the Review Panel that in June 2019, a support worker had completed work on sex education and healthy relationships with Koffi.

14.11.15. The Review Panel was informed that as part of this work, he was briefed about the laws in the United Kingdom, safety in relation to sex, and the risks that are involved. During this work, Koffi was asked about his thoughts on a healthy relationship and what he felt a relationship in the United Kingdom looked like. The Review Panel was informed that it would have been the decision of his support worker to revisit these areas if it was deemed relevant. These matters were not revisited after the incident in October 2020.

14.11.16. There was limited focus by Children's Social Care on reducing the impact of Koffi's offending behaviour and the impact of this on Tay and Marley. It was documented that Tay had stated to Children's Social Care that she would end the relationship if there were any repeat behaviours from Koffi. The Review Panel was unanimous in their analysis that the onus on reducing the impact to Tay and Marley should not have been placed on Tay.

14.11.17. Within the Early Help action, it was documented that one of the areas to be addressed was for Koffi to access support on domestic abuse. However, the records did not provide any detail as to what this support was. This action was still outstanding at the time of Tay's murder.

14.11.18. The Review Panel has seen no evidence that any work or intervention was undertaken with Koffi to address his offending behaviour. There were no information or records provided to the review that documented that Koffi had been spoken to about the abuse he had perpetrated, other than a conversation undertaken by his support worker.

14.12. **Term 10**

14.12.1. **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?**

14.12.2. The Review Panel has identified that there were a number of agencies who were involved with Tay, Koffi, and Marley, that were not aware of the domestic abuse incident and MARAC. These included Bedspace, Talk Liverpool, and GP Practices. This impacted on the MARAC held in November 2020, as key agencies who held vital information were not aware and part of the process. The Review Panel considers this to be a significant area of learning for Liverpool Community Safety Partnership.

14.12.3. The Review Panel has identified other areas of learning in relation to multi-agency working and information sharing, which has been captured in Term 7.

14.13. **Term 11**

14.13.1. **How effective was your agency's supervision and management of practitioners involved with the response to the needs of Tay and Koffi, and did managers have effective oversight and control of the case?**

14.13.2. There were limited management and supervision notes documented in Koffi's Children Social Care file. The Review Panel was informed that where there were entries, then these related to tasks, performance, and compliance indicators only.

14.13.3. Within the case for Marley, there was an allocation note from a manager for the time period of this review – with no reflection or supervision in relation to the referral following the domestic abuse incident in October 2020.

14.13.4. There was a management oversight at the point of case closure, which documented: 'I recommend that the family are supported via a Child in Need plan, however, this has been declined, parents feel that they have addressed the issue in respect to Koffi's mental health, he has seen his GP and is accessing support via Talk Liverpool. They feel that they have support in the health visitor and Koffi has a personal assistant who can offered further advice when required. Parents have agreed to engaging with Early Help and Assessment Team (EHAT). Given that the threshold is not met for a section 47 enquiry the case should step down to EHAT'.

14.13.5. The Review Panel agreed that had there been a robust supervision and management of this case, then key facts and indicators would have been identified and addressed.

14.13.6. The Review Panel was informed by Children's Social Care that there is now a practice standard where direct supervision takes place at a minimum of every 3 months for each child/young person, and this reflects the needs of the young person, what the risks and support needs are, along with impact and outcomes. Management oversight is tracked by a dashboard to ensure quality and consistency is good. This is overseen by the data team and senior leadership team.

14.13.7. In January 2020, a UASC team was established in Liverpool due to the increasing number of unaccompanied young people arriving in Liverpool and an acknowledgement that this required a specialist area of support.

14.13.8. Prior to this, assessments of young people were undertaken in area teams. The UASC team had progressed and developed over time to ensure access to services and the needs of young people were met. The UASC team consists of trained and experienced social workers, support staff, and

management. There are established links with accommodation providers who are able to meet the cultural, religious, educational, and health needs of young people placed with them. Providers undertake direct work with the young people to support them in their understanding and settling in Liverpool. There are established links with independent support services, such as Red Cross and Asylum Link, who ensure interpreters are available for meetings and interactions with young people, where required.

14.13.9. The team is responsible for needs and age assessments and supporting young people through to independence / outcome of asylum claim. The Review Panel was informed that this has provided greater oversight and understanding for the local authority, of young people entering the United Kingdom and supporting the young people through experienced trauma.

14.13.10. Within the IDVA service, case files are reviewed every six weeks as part of Supervision Processes. This is in addition to regular discussion and ongoing oversight of cases, which address where there are concerns that are not being addressed, ongoing risk and escalation in frequency, and severity or repeat incidents. Cases are also reviewed as part of MARAC research processes and following MARAC discussion.

14.13.11. The supervision provided by Liverpool Women's Hospital was appropriate for this case. Midwives who hold child protection or domestic abuse cases, have access to regular safeguarding supervision. The Review Panel was informed that cases are flagged and midwifes have open access to the safeguarding team for support and direction throughout the maternity care provision. Following the death of Tay, extensive case supervision was provided to the community midwife involved.

14.13.12. There was no record within health visiting records that supervision was sought during the time Tay was offered health care. The Review Panel was informed that practitioners are supported to bring any safeguarding cases with a cause for concern, to supervision.

14.13.13. The Rapid Review undertaken by the police, following the death of Tay, focussed on the supervision and management of this case, which identified learning for the Force in relation to the supervision, management, and allocation of domestic abuse cases. The learning has been addressed in Term 15 and will therefore not be repeated here.

14.14. **Term 12**

14.14.1. **Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?**

14.14.2. The learning from this review has not previously been identified in other reviews.

14.15. **Term 13**

14.15.1. **What knowledge did family, friends, and employers have that Tay was in an abusive relationship, and did they know what to do with that knowledge?**

14.15.2. Tay's employers were not aware that she had been a victim of domestic abuse.

14.15.3. The Review Panel has learnt that some of Tay's family and friends were aware of incidents that amounted to domestic abuse. They supported Tay, for example, by providing brief temporary accommodation. One family member advised Tay that Koffi's conduct was domestic abuse, and she did not have to put up with it.

14.15.4. The Review Panel reflected that family and friends of Tay did not report the domestic abuse to agencies. The Review Panel considered if family and friends had not reported the abuse, due to the fact that Tay had moved out of the address after the incident, to stay with family and that Tay was being supported by agencies as well as making plans to source her own accommodation and live independently. The latter which family were supporting her to achieve.

14.15.5. The Review Panel sought assurances of the availability of information for family and friends who have concerns about domestic abuse within a relationship. A search of 'domestic abuse support Liverpool' produces links to Liverpool Domestic Abuse Service[51], Liverpool City Council website[52] - which provides links and information to local and national agencies and Merseyside Police website[53].

14.15.6. The Review Panel reflected that family and friends of Tay did not report the domestic abuse to agencies. The Review Panel considered if family and friends had not reported the abuse, due to the fact that Tay had moved out of the address after the incident, to stay with family and that Tay was being supported by agencies as well as making plans to source her own accommodation and live independently. The latter which family were supporting her to achieve.

14.15.7. The Review Panel discussed the external pressures that may have impacted on Tay: this may have included a feeling of responsibility towards Koffi, given his asylum status, his isolation, and lack of support of his family and friends. The Review Panel agreed that these, along with Tay's age and her vulnerabilities, will have increased the risk towards her around the time she was moving into her own accommodation. This has been covered in Term 1.

14.16. **Term 14**

14.16.1. **Were there any examples of outstanding or innovative practice?**

14.16.2. There were no examples of outstanding and/or innovative practice identified during this review.

14.17. **Term 15**

14.17.1. **What learning did your agency identify in this case?**

14.17.2. <u>Bedspace</u>

- Multi-agency information sharing.

[51] https://liverpooldomesticabuseservice.org.uk/
[52] https://liverpool.gov.uk/communities-and-safety/crime-and-safety/domestic-abuse/
[53] https://www.merseyside.police.uk/advice/advice-and-information/daa/domestic-abuse/support-organisations/

14.17.3 GP Practice (Tay)

- Multi-agency information sharing.
- Notification of death of Tay.

14.17.3. **Action taken to address this learning:**

- The learning was identified and addressed, following the completion of the Significant Event Analysis completed after Tay's murder.

14.17.4. Liverpool City Council Children's Social Care

- The information exchange, when a child referred to Children's Social Care is a Care Leaver and accessing services as such.
- The information exchange, and required expectations, of receiving practitioners when assuming case responsibility.

14.17.5. **Action taken to address this learning:**

- Both will be subject to further exploration through audit, to establish if these are enduring concerns across social care.

14.17.6. Local Solutions / IDVA Service

- The importance of face-to-face contact.

14.17.7. **Actions taken to address this learning:**

- This contact occurred during the Covid-19 pandemic when restrictions were in place for face-to-face contact. IDVA is currently reviewing their processes and delivery and will prioritise face-to-face contact where it is safe and in the best interest of the victim/survivor.

14.17.8. **Mersey Care NHS Foundation Trust**

- Information sharing, professional curiosity, and training.
- Management of VPRFs.
- Management of MARAC feedback.

14.17.9. **Action taken to address this learning:**

- Talk Liverpool now attend the Liverpool MARAC to inform the sharing of information and safety planning, for victims and perpetrators known to their

service. They also receive Liverpool VPRFs, which identify an individual's vulnerability.

- Talk Liverpool leads are currently devising a Standard Operating Procedure to support the management of domestic abuse cases.

14.17.10. Merseyside Police

14.17.10.1. The Rapid Review completed by Merseyside Police, identified the following four areas of learning. These are detailed below, with a further recommendation identified by the IMR author from Merseyside Police:

I. Consider canvassing all Protecting Vulnerable People Unit (PVPU) supervisors and managers regarding their knowledge of Evidence Led Prosecutions (ELP).

II. Consider further training for all PVPU staff in relation to Evidence Led Prosecutions.

III. Consider a review of domestic abuse cases involving Gold victims and named suspects that have been filed No Further Action, to ascertain if Evidence Led Prosecutions was considered.

IV. Consider formal training for all PVPUs staff prior to their posting to a local PVPU.

14.17.11. **Action taken to address this area of learning:**

14.17.12. Response to 1 and 2

14.17.13. The following initiatives were already in place by 6 October 2020. On 15 November 2019, with domestic homicides at their highest level for five years, a two-month Intensification Period commenced, focussing on domestic abuse: it coincided with a United Nations period of action in this regard. This was repeated in 2020 and has now become an annual event each November and December. The Force also delivers Continuous Professional Development events throughout the year, with the aim of improving the quality of domestic abuse investigations.

14.17.14. Whilst the Force investigation strand leads on these initiatives, other strands, such as Response and Resolution and local policing, deliver at a local level to ensure the same high-quality investigations and ELPs.

14.17.15. During the 2021 Domestic Abuse Intensification Period, a Domestic Abuse Audit team, comprised of a mixture of police officers from all strands, was established: the aim of which was to identify learning where the Force could improve the policing response and the victim/survivor experience. Positive and learning feedback was provided to officers. The Force saw improvements in the Domestic Abuse Quality Assurance completion, increased use of Body Worn Video, and an increased rate in solved cases for the months of November and December 2021.

14.17.16. In addition, Operation Cornerstone, which utilises a domestic abuse car staffed by experienced officers, aims to reinforce the role of first responders to 'get it right' at the point of first response, by supporting initial response and by identifying opportunities for ELP.

14.17.17. The Crown Prosecution Service (CPS) was provided with a dip sample of 10 cases per month, not previously referred to them for charging advice, to seek comments on the likelihood of ELP. Key themes were identified, and a finalisation template was formulated to ensure all ELP opportunities were considered. At the time of Merseyside Police completing their IMR, ELP submissions to CPS with successful outcomes, are being monitored: the latest figures available show charges have been authorised in 40% of ELP cases, with a conviction rate of 41%.

14.17.18. <u>Response to 3</u>

14.17.19. 189 domestic abuse offences were reviewed. A range of bronze, silver, and gold offences were highlighted, resulting in key learning being identified and recommendations made.

14.17.20. <u>Response to 4</u>

14.17.21. A Vulnerability Programme of one days' duration was developed by a Protecting Vulnerable Team and The Training Academy, to reach all frontline officers and investigators.

14.18. **Term 16**

14.18.1. **How did your agency take account of any racial, cultural, linguistic, faith, or other diversity issues, when completing assessments and providing services to Tay and Koffi?**

14.18.2. **Use of Interpreter**

14.18.3. Koffi's first language was French. There was evidence in some agencies' records that an interpreter was used during contact; however, this was not consistent throughout all agencies. The Review Panel heard how Koffi's use of the English language developed over time through attendance at education classes and day-to-day contact; however, he needed an interpreter for 'official' and more in-depth discussions.

14.18.4. During initial contact with Children's Social Care, an interpreter was used to support discussions. This was not continued throughout Children's Social Care's involvement. Whilst records documented that Koffi's use of English had improved, there was no record or acknowledgement of his true understanding.

14.18.5. The review has seen evidence that Koffi's support worker used 'google translate' to help facilitate communication with Koffi during early engagement.

14.18.6. Talk Liverpool utilised an interpreter for all sessions supporting Koffi, Koffi's initial assessment with Talk Liverpool was cancelled due to the interpreter not being available. The assessment was rearranged.

14.18.7. An interpreter was used during meetings about his asylum application and during his asylum hearing in January 2021.

14.18.8. The Review Panel discussed the disparity in agencies' approach and use of interpreters by professionals who engaged with Koffi. It was

determined that whilst Koffi's use of the English language had improved over time, the Review Panel felt that this may have led to an acceptance that Koffi understood the details of conversations that had taken place, and therefore an interpreter was not always used. The Review Panel has identified this as a point of learning and made a relevant recommendation.

14.19. **Culture and Diversity**

14.19.1. There was also limited reference held by agencies involved in the review in relation to Koffi and Tay's racial, cultural, linguistic, faith, or other diversity issues.

14.19.2. When Koffi arrived in Liverpool, he started attending a local church and told professionals that he wanted to become a Christian. Koffi had been brought up as a Muslim. There was no record seen by the Review Panel as to whether this was explored by professionals.

14.20. **Tay**

14.20.1. Children's Social Care did have a reference that Tay had preconceived ideas about their involvement with Koffi; however, there were limited indications, or a record of attempts, to inform her understanding as to the support Koffi was entitled to as a Care Leaver and previous unaccompanied asylum- seeking child.

14.20.2. Tay was offered support from the IDVA specialist young person's worker who specialises in supporting people aged 16-24, and also due to her being a young mother.

15. Conclusions

15.1. Tay was murdered by Koffi. At the time of her murder, Tay was due to move into her own accommodation along with Marley. Tay had recently returned to work, following a period of maternity leave. Tay was returning to a job that

she thoroughly loved, with the added benefit that Marley would be with her whilst she was at work.

15.2. During the completion of this review, the Review Panel struggled to capture the voice of Tay. This can be attributed to limited contact that Tay had with professionals during the early timescales of the review; however, the Review Panel was conscious that this provided an imbalance in the report, as the majority of professionals' focus and engagement, for the review period, was with Koffi.

15.3. Koffi entered the United Kingdom as an unaccompanied asylum seeker. Following an age assessment in May 2018, it was determined that Koffi was a child, and he was placed in the care of the local authority. Koffi applied for Leave to Remain in the United Kingdom: this was initially refused, and Koffi appealed against the decision. In February 2021, Koffi was granted Leave to Remain in the United Kingdom.

15.4. At the start of 2020, Tay and Koffi began their relationship. A short time later, Tay became pregnant with Marley, and she moved in with Koffi. Whilst this was in breach of tenancy agreements, the arrangement was allowed to continue due to Tay's pregnancy.

15.5. In October 2020, Koffi assaulted Tay. Marley was a few weeks old at the time of this incident. During contact with the police and IDVA, Tay reported that she had been subjected to physical abuse and coercion and control from Koffi on more than one occasion, and that the level of abuse was escalating. Koffi was not seen or spoken to by the police regarding the domestic abuse.

15.6. The case was referred to MARAC and shared with agencies. The review has identified that there were some agencies, who held significant information, that were either not aware of the domestic abuse or contacted to provide information as part of multi-agency discussions and assessments.

15.7. Professionals who had contact with Tay and Koffi did not proactively seek to gather detailed background information, nor seek to verify information that

had been provided. Professionals' involvement relied on an acceptance that the information provided was accurate. This was misconstrued.

15.8. The review found that there was little emphasis on Koffi's cultural background, childhood, and mental health, and whether this had any impact on his relationship with Tay. impact on his relationship with Tay. Tay and Koffi were a young couple who were finding their way in life. They each had their own vulnerabilities and were learning how to share their life with a young baby, in addition to the uncertainty around Koffi's legal status to remain in the United Kingdom. The review found that professionals did not consider the holistic circumstances of this case.

15.9. The review has identified learning at a strategic level for all agencies involved in this review. This learning is in addition to single agencies' learning and recommendations.

15.10. Tay's family were involved in the review process, and the Review Panel wish to express its thanks for their contribution.

16. Learning Identified

16.1. **The Domestic Homicide Review Panel's Learning (arising from panel discussions)**

16.1.1. The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at Term 15. Each area of learning is preceded by a narrative that seeks to set the context within which the learning sits. Where learning leads to an action, a cross-reference is included within the header.

16.2. **Learning 1 [Panel recommendation 1 and 2]**

16.3. **Narrative**

16.3.1. There were opportunities on this case, for professionals to have obtained further detailed information about the subjects of the review, including background information, living arrangements, and whether there

were other professionals working with and/or providing services. In addition, there were incidents where when information was shared, this was taken at face value and not challenged, checked, or verified.

16.4. **Learning**

16.4.1. Had these details been sought, then it may have provided professionals with opportunities to seek further information to inform ongoing assessments and the identification of any presenting risk factors. Professionals need to demonstrate a proactive approach to gathering information and adopting a 'trust but verify' approach on information that has been shared.

16.5. **Learning 2 [Panel recommendation 3]**

16.6. **Narrative**

16.6.1. There were agencies involved in this review that held information that could have been shared within the MARAC, to inform risk assessment and planning.

16.7. **Learning**

16.7.1. All relevant agencies involved within individuals subject of MARAC, should be provided with an opportunity to contribute to the MARAC process – by the sharing of information and, where relevant, attending MARAC meetings.

16.8. **Learning 3 [Panel recommendation 4]**

16.9. **Narrative**

16.9.1. Staff providing support to Koffi had not received training on domestic abuse.

16.10. **Learning**

16.10.1. By receiving training on the dynamics of domestic abuse, it will support professionals in their recognition, understanding, and responses to domestic abuse and identified risk factors.

16.11. **Learning 4 [Panel recommendation 4]**

16.12. **Narrative**

16.12.1. Higher education providers held relevant information that would have informed assessments on this case. It would have provided higher education providers to have contributed to multi-agency working and respond to Koffi's domestic abuse offending.

16.13. **Learning**

16.13.1. Information sharing pathways will allow for safeguarding concerns to be shared and information to be gathered, to inform risk assessment and multi-agency working.

16.14. **Learning 5 [Panel recommendation 6]**

16.15. **Narrative**

16.15.1. This case was stepped down from Child in Need to Early Help, with an agreed action plan to address areas of safeguarding. Those actions were not progressed, and there were limited records as to what actions were being taken to review the concerns. This included the verification of information that had been provided to inform the action plan.

16.16. **Learning**

16.16.1. There must be in place, a process of robust co-ordination, supervision, and management of Early Help action plans to ensure that safeguarding concerns are being addressed.

16.17. **Learning 6 [Panel recommendation 7]**

16.18. **Narrative**

16.18.1. Koffi's first language was not English. At times, contact with professionals was undertaken with the aid of an interpreter. Written communication was sent in English.

16.19. **Learning**

16.19.1. Contact with individual's whose first language is not English, whether that contact is verbal or written, must be in their preferred language to ensure that this contact can be understood.

16.20. **Learning 7 [Panel recommendation 8]**

16.21. **Narrative**

16.21.1. Koffi came to the attention of the police as a perpetrator of domestic abuse. Details of this incident were not known and therefore not considered as part of the asylum appeal and hearing processes.

16.22. **Learning**

16.22.1. As part of the decision-making process for those seeking asylum should take account of intelligence held by the police so that consideration can be taken as part of asylum application processes.

17. Recommendations

17.1. **Panel Recommendations**

Recommendation
1. That all agencies provide evidence that professionals are adopting a proactive approach to gathering information from individuals, and where additional sources of information are identified, this is followed up.
2. That all agencies provide evidence that professionals are adopting a 'trust but verify' approach when working with individuals, which includes the accurate recording and verification of information to inform assessment and risk planning.
3. That MARAC Steering Group provides Liverpool Community Safety Partnership with a report as to individual agencies' contribution and representation at MARAC. The report should identify what action is being taken to address any identified gaps within multi-agency involvement, including involvement of non-statutory organisations. This recommendation can be achieved through an audit of MARAC attendance – to identify gaps and provide City Safe Board with information to address gaps with partners at a strategic level.
4. That Bedspace provides Liverpool City Council Safer & Stronger Communities Team with a report as to the timescales for the implementation of domestic abuse training to their staff. Updates to the implementation can be provided at 3-, 6- and 12-month intervals.
5. That further and higher education providers work closely with MARAC Steering Group to develop information sharing pathways in relation to domestic abuse incidents and safeguarding concerns.
6. That Liverpool Children's Social Care provides a report to Liverpool Community Safety Partnership on the co-ordination, supervision, and management of Early Help action plans. That report should address the identified learning within this review.
7. That all agencies should provide Liverpool City Council Safer & Stronger Communities Team with evidence and assurances that any contact, whether verbal or written, with individuals whose first language is not English, is undertaken in a format in which they can understand.

Recommendation
8. That Home Office and United Kingdom Visa and Immigration Service should ensure that local intelligence regarding those seeking asylum is taken into account as part of the decision-making process for those charged with considering asylum applications.

17.2. **Single Agency Recommendations**

17.2.1. Single agency recommendations are contained within the action plan.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: during timescales of review

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

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

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance, and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[54]

The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.

Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.

This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family.
- depriving them of their basic needs.
- monitoring their time.

[54] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- monitoring a person via online communication tools or using spyware.
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep.
- depriving them of access to support services, such as specialist support or medical services.
- repeatedly putting them down such as telling them they are worthless.
- enforcing rules and activity which humiliate, degrade, or dehumanise the victim.
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities.
- financial abuse including control of finances, such as only allowing a person a punitive allowance.
- threats to hurt or kill.
- threats to a child.
- threats to reveal or publish private information [e.g., threatening to ‘out’ someone].
- assault.
- criminal damage [such as destruction of household goods].
- rape.
- preventing a person from having access to transport or from working.

This is not an exhaustive list.