Kirklees Safeguarding Adults Board and Communities Board

Joint Safeguarding Adults Review and Domestic Homicide Review concerning Mrs S. McKenzie who died on 8th December 2022

Review completed by Barrie Crook on 22/05/2024

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This report has been jointly commissioned by Kirklees Safeguarding Adults Board and the Kirklees Communities Board, since it was considered that the death of Mrs. McKenzie met the criteria for both a Safeguarding Adults Review (SAR) and a Domestic Homicide Review (DHR).

A Safeguarding Adults Board (SAB) is required to undertake a Safeguarding Adults Review where:

- An adult with care and support needs has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- Both Mrs. and Mr. McKenzie had been in receipt of services for health conditions and are considered to have been adults at risk. The Safeguarding Adults Board SAR subgroup decided that the agencies involved with both parties could have worked together more effectively to protect Mrs. McKenzie and that the criteria for a SAR were therefore met.

The purpose of a SAR is to enable lessons to be learned so that future deaths from abuse, neglect or self-neglect can be prevented. Domestic abuse is specified in the Care Act 2014 as one of the types of abuse. The focus of a SAR is upon the quality of care and treatment provided by agencies, in this particular review to both Mrs. and Mr. McKenzie. Given the circumstances of the death and the vulnerability of Mr. McKenzie he will not be termed the 'perpetrator' in this report.

The key purpose for undertaking a DHR is also to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. Professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. Mr. McKenzie. was charged with the murder of his wife on the 9th December and remanded in custody to await trial. Both parties were resident in their shared home in Huddersfield at the time of Mrs. McKenzie's death. However, Mr. McKenzie died in prison on March 4th, 2023, without being convicted. He had been diagnosed with late onset Alzheimer's disease prior to the death of his wife. When arrested by the Police he was considered Fit to be Detained but not Fit to be Interviewed.

The care and support needs experienced by Mrs. and Mr. McKenzie became strongly linked to the risk of potential harm to Mrs. McKenzie from her husband.

2 Timescales

The Kirklees DHR Standing panel determined that the criteria for a DHR were met on 26/01/2023. The Chair of the Safeguarding Adults Board confirmed that the threshold for a SAR had also been met on 31/01/2023. At this point court proceedings in respect of the alleged homicide were ongoing.

At the first panel meeting relevant agencies were identified and individual chronologies of contacts with both parties were requested. The independent author was commissioned in May 2023 and began work in August once the chronologies and Individual Management Reviews had been produced.

A final draft report was agreed by the panel on 7th February 2024. There have been subsequent delays in discussing the report with the family of Mrs. McKenzie, which are explained in more detail in section 6.2.

3 Confidentiality

The names of Mrs. and Mr. McKenzie have been anonymised following contact with family members. To preserve confidentiality and encourage openness to learning no members of staff who were in contact with them have been named in the report.

4 Terms of reference

The key issues to be considered in the review were set out as follows.

Engagement with services/their care experience – understanding how these individuals engaged with services providing care and if their care experience may have affected future engagement with services will enable us to share best practice and support service improvements.

Indications of self-neglect – understanding how evidence of self-neglect was recognised and responded to will support us to improve our co-ordinated multi-agency approach so self-neglect can be identified and responded to effectively at the earliest opportunity.

Support for either party as a carer – understanding how professionals identified individuals as carers and supported both parties in their caring roles so improvements can be made in how our multi-agency partnership identifies and supports carers.

Evidence/indications of domestic abuse – central to a DHR is improving our understanding of domestic abuse and how our services respond to victims and children. Understanding how disclosures and/or other evidence of domestic abuse were recognised and responded to will support us to improve our co-ordinated multi-agency approach so domestic abuse can be identified and responded to effectively at the earliest opportunity.

Impact of covid – considering if the Covid 19 pandemic impacted on:

- their relationship, caring responsibilities and carer stress; and
- agency involvement / response times/ service delivery
- and, if so, if there are improvements to be made to existing services to mitigate this impact.

The analysis of agency information will enable us to determine if:

- agencies effectively worked together, shared information and responded in a coordinated way at key points (i.e. when safeguarding concerns were identified)
- risks were identified, assessed, managed and responded to appropriately
- there is evidence of Making Safeguarding Personal (Quality Marker 2.2.6)
- practitioners were supported to work in a trauma-informed manner and take due regard to Professional Curiosity

- there is evidence that race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 have been considered, including recognition of unconscious bias (Quality Marker 2.1.4 & 2.2.7)

5 Methodology

The overview report has been compiled from analysis of the multi-agency chronology and the information supplied by the agencies involved with Mrs. and Mr. McKenzie through the Individual Management Reviews (IMR) listed in 7.1. Agencies were asked to address the specific issues set out in the terms of reference, identifying good practice and learning points to improve future practice. Each organisation confirmed that the IMRs had been prepared by a suitably qualified member of staff and quality assured before submission.

Background information was sought from Mrs. McKenzie's next of kin, Mr. McKenzie's sister and two neighbours who knew the couple well and supported them in their daily lives.

A review panel has met on five occasions to oversee production of the review. There have been two meetings with practitioners directly involved with Mrs. and Mr. McKenzie and their managers.

The author has requested additional source material from agencies, reviewed the recommendations from a previous SAR into the death of a man with dementia in Kirklees and drawn on relevant publications concerning domestic abuse of older people.

5.1 Involvement of family and neighbours

Contact was made with Mrs. McKenzie's cousin and next of kin who expressed a wish to be involved in the review. Although she had not seen her cousin for approximately 5 years, she was able to provide background details about her early life and hospital admission in 2016.

Although Mrs. McKenzie's cousin and her advocate from Victim Support received a copy of the final draft report in February 2024, it has so far not been possible to discuss the findings with them. Mrs. McKenzie's cousin has experienced further family bereavements and does not yet feel ready to consider in detail the circumstances of the loss of her cousin.

Mr. McKenzie's sister has also contributed information concerning his family background and her perceptions of the couples' marital relationship. She had last spoken to Mrs. McKenzie approximately two weeks before she died. She and her husband have reviewed and endorsed the final draft report. They believe the couple were let down by the agencies involved and feel that a different approach was required to gain Mrs. McKenzie's trust and confidence.

The author has also discussed the review with two of Mrs. and Mr. McKenzie's neighbours who had lived close by for several years and had provided support to the couple, particularly when Mr. McKenzie's health began to fail because of dementia. Both gave witness statements to the Police concerning the homicide.

5.2 Contributors to the review

Agencies were asked to search their records and establish if they held any information in respect of any of the subjects of this review. The panel scrutinised the information provided by these agencies and then asked those that held relevant information to provide further details. The table below shows each of the agencies that were contacted, whether any of the subjects were known to them and what information they then provided. The following organisations prepared Individual Management Reviews (IMR).

Agency	Submit information	IMR	Panel member
Kirklees Council			
Adult Services – Adults Social Care	✓	✓	✓
Communities Service			✓
Criminal Justice			
West Yorkshire Police	✓	✓	✓
HMP Leeds	✓		
Health			
Kirklees Integrated Care Board - Continuing Health Care - GP practice	✓	✓	✓
Calderdale and Huddersfield NHS Foundation Trust	✓	✓	✓
Locala	✓	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓	✓
Specialist Services			
Pennine Domestic Abuse Partnership			✓
Other			
Department for Work and Pensions	✓		✓
Nova Care	✓	✓	✓
Curo	✓		

5.2.1 Calderdale and Huddersfield NHS Foundation Trust (CHFT)

Mrs. McKenzie was treated at Huddersfield Royal Infirmary in 2016 and attended appointments at the vascular outpatient clinic from 2019.

5.2.2 Kirklees Adult Social Care (ASC)

Commissioned packages of care for both Mr. and Mrs. McKenzie. Provided equipment including a stairlift.

Kirklees Health and Care Partnership, part of West Yorkshire Integrated Care Board, on behalf of the GP practice at which Mrs. and Mr. McKenzie were registered from 22/12/2003

5.2.3 Locala Health and Wellbeing, a not for profit healthcare provider

Provided Community Nursing support to Mrs. McKenzie from 2017-22

Nova Care Yorkshire, a provider of home care support to individuals residing in their own homes. Delivered carer support to Mr. McKenzie from October 2022

5.2.4 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

Mr. McKenzie attended six sessions of counselling with the Access to Psychological Therapies (IAPT) in 2012. He was assessed by the Memory team in 2022.

5.2.5 West Yorkshire Police

Responded to a 999 call by Mrs. McKenzie in September 2022 and attended her home on the night of the homicide.

5.3 Review panel members

The Review Panel met on five occasions. Membership was as follows:

Name	Role & Agency
Gwen Clyde-Evans	Designated/ Deputy Professional Nurse for Safeguarding Adults and Children , Kirklees Health and Care Partnership (Chair)
Emma Cox	Associate Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust
Carol Morgan	Specialist Advisor Safeguarding Adults, South West Yorkshire Partnership NHS Foundation Trust
Chani Mortimer	Service Manager Domestic Abuse, Kirklees Council
Jacqui Stansfield	Service Manager Kirklees Safeguarding Adults Board
Sarah Moore	Director, Nova Care (from November 2023)
Claire Westmoreland	Named Nurse for Safeguarding Adults and Children at Risk, Locala

Name	Role & Agency
Julie Brice	Named Nurse for Safeguarding Adults and Children at Risk, Locala
Kathryn Hinchliff	CEO, Pennine Domestic Abuse Partnership
Gail Adinall	Head of Service, Kirklees Adult Social Care
Paulette Morris	Service Manager, Kirklees Adult Social Care
Terryann Shaw	Dementia Strategic Partnership Manager, Kirklees Council
Tracy Kershaw	Deputy Designated Nurse for Safeguarding Children and Adults, Kirklees Integrated Care Board
Alison Knight	Advanced Customer Support Senior Leader, Department of Work and Pensions
Jill Greenfield	Service Director Communities and Access Services – Kirklees Council
Karen Booth	Safeguarding Partnerships Officer – Safer Kirklees
Lee Fletcher	Detective Chief Inspector, West Yorkshire Police
Alison Edwards	Head of Safeguarding, Calderdale and Huddersfield Foundation Trust
Gill Skelton	Business Support, Kirklees Council

5.4 Author of the overview report

Barrie Crook is independent of all the agencies involved in the review. He was independent chair of two Safeguarding Adults Boards for five years before practising as an independent reviewer. During that time he chaired panels for SARs and DHRs and oversaw the completion of action plans to implement recommendations arising from them.

From 2005 – 2014 he was Chief Executive of Hampshire Probation Trust and led a number of multi-agency initiatives in the criminal justice system.

5.5 Parallel reviews

The inquest into Mrs. McKenzie's death was held in September 2023. The cause of death was established as:

Head and Neck Injuries and Severe Chronic Multisystem Comorbidity

Mr. McKenzie died in prison. The Prisons and Probation Ombudsman (PPO) is responsible for investigating deaths in prison custody. Although Mr. McKenzie's death in not in scope for these reviews, the PPO has provided information concerning the continuing impact of his health condition upon his behaviour while in prison. It has also been possible to talk to the Head of Healthcare at Leeds prison where he was remanded. The Coroner recorded that the medical cause of his death was.

- Cerebral Infarction
- Cerebrovascular Atherosclerosis and
- Vascular Dementia

6 Equality and diversity

Both Mrs. and Mr. McKenzie were White British. Mrs. McKenzie required a wheelchair to mobilise and would be likely to have been regarded as disabled under the Equality Act, although this is not recorded in her medical or other agencies' notes.

7 Dissemination

The review will be shared with the following organisations.

- Kirklees Domestic Abuse Partnership/Community Safety Partnership
- Kirklees Council Adult Social Care
- Kirklees Council Housing
- West Yorkshire Police
- West Yorkshire Police and Crime Commissioner
- Integrated Care Board
- General Practitioner via the ICB
- Calderdale and Huddersfield NHS Foundation Trust
- South West Yorkshire Partnership Foundation Trust
- Mid Yorkshire Teaching Trust
- Locala CIC
- Pennine Domestic Abuse Partnership
- Department of Work and Pensions
- HM Coroner (if requested)

8 Background information

The outcome of the inquest into Mrs. McKenzie's death was a narrative verdict which provides a succinct summary of the facts of the homicide.

“Upon the 8th December 2022, a neighbour of Mrs. McKenzie[1] called West Yorkshire Police to attend at the home of Mrs. McKenzie, following a confession made by the husband of Mrs McKenzie to her who stated that "I have killed her". The Emergency Services attended at the home of Mrs McKenzie, and found her to be in an unresponsive condition, resuscitative care was provided to her at her home, and subsequently during transportation, to Huddersfield Royal Infirmary; where the death of Mrs. McKenzie was certified at 23:53 hours that day.[2] Mr. McKenzie was arrested by the Police and charged with the murder of his wife: he was subsequently remanded in custody whilst awaiting trial of the charges laid against him. Whist remaining in custody Mr McKenzie suffered a fall in January 2023, however, despite receiving medical care his condition deteriorated, with his death being certified on 4th March 2023. Following the death of Mr McKenzie the criminal proceedings against him were discontinued. “

9 Chronology

Background information about Mrs. and Mr. McKenzie has been provided by Mrs. McKenzie’s cousin with whom she shared her early years and Mr. McKenzie’s sister.

Mrs. McKenzie grew up in Farnborough, Hampshire. She experienced a financially poor childhood. Her mother is described as having been eccentric and an inconsistent parent, leading to Mrs. McKenzie missing a lot of school. As children both Mrs. McKenzie and her cousin were frightened of her father. Her first job was as a shelf stacker for Tesco. She married Mr. McKenzie in March 1973. Her cousin describes him as clever but shy, having little confidence in himself. They moved away from Farnborough as he did not get on with Mrs. McKenzie’s mother. A period in the Lake District was followed by them settling in Huddersfield, where her cousin remembers them having a comfortable lifestyle, often travelling abroad to follow Mr. McKenzie’s love of motor racing.

There were two incidents in Mrs. McKenzie’s life which may have had a long-term traumatic impact upon her. When she was a young child Mrs. McKenzie broke her arm. This led to a period in hospital when she did not see her parents and became very upset. When finally discharged she broke the arm again within a matter of weeks and was again admitted to hospital. Her cousin remembers that this left her with a phobia of hospitals.

In 1974 the couple lost an infant son who died shortly after birth. The child was named and Mrs. McKenzie talked about her to her cousin some years later. The couple did not have any other children.

Her cousin had not seen Mrs. McKenzie since she was discharged from hospital in 2017. She believes that the marital relationship began to change when Mr. McKenzie was diagnosed with epilepsy and also after he threw a plate at Mrs. McKenzie in 2012. Another cousin received letters from Mrs. McKenzie in which she wrote of having great difficulties. Mr. McKenzie was swearing a lot and calling her names. She wrote about him not recognising her or seeing two of her and about planning to find a place of her own after Christmas.

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[1] The names of both parties have been changed in this quotation to be consistent with those used in the remainder of the report.

[2] The Individual Management Review (IMR) of Calderdale and Huddersfield NHS Foundation Trust records the time of death as 00:43 on December 9th. For the purpose of this review the date and time accepted by the Coroner’s inquest will be used.

Mr. McKenzie's sister outlined that he did not enjoy a good relationship with his father, who was strict with him. The family were pleased when he married Mrs. McKenzie She remembers a happy marriage and that Mr. McKenzie doted upon his wife.

She was aware that her brother received counselling in 2012. She felt that this was triggered by the death of his father and their younger sister. Mr. McKenzie was particularly upset by the loss of his sister and did not feel able to attend her funeral. Mr. McKenzie's father also had dementia and she remembers that the onset and course of his illness was very similar to that experienced by Mr. McKenzie Although he was noisy and sometimes agitated, he was not aggressive. Mr. McKenzie and his sister became closer after 2012 and, although visits were rare, kept in touch via Skype.

She observed that Mr. McKenzie was experiencing symptoms of dementia about 6-9 months before it was diagnosed. Aspects of his behaviour changed, for example he became frightened of using the telephone. She was aware of an incident when he tried to push his wife out of the door. She afterwards asked Mrs. McKenzie if she was afraid of him. Mrs. McKenzie had said that she was not. Their last contact was a phone conversation about two weeks before her death, when no concerns were raised.

9.1 Overview

This section of the report focusses upon Mrs. and Mr McKenzie's health and social care needs commencing in 2010.

Mr. McKenzie had a history of high blood pressure, stomach problems and anaemia. In 2010 he was diagnosed with epilepsy and was under the care of Neurology specialists until 2015, when it was felt that the medication regime was controlling the epilepsy.

In May 2012 he was referred to the IAPT service. He had been reported missing from home and was in a depressed state. The catalyst for a dip in mood had been his epilepsy. His childhood seizures had returned 5 years before and were increasing in frequency. At the time he was trying different prescribed medication to control the epilepsy. He described a very strict childhood and the two recent family bereavements, feeling he had not grieved properly for them. He felt like lashing out at his wife when they had arguments but would walk out of the house if it got to that point. Previous cognitive behavioural therapy had not helped him. He shared previous suicidal thoughts.

Over a series of six counselling sessions he talked frequently about difficulties in his relationship with his wife. He was worried that he may be repeating behaviour of his father. In September 2012 at the final session he described feeling more positive that his home life had improved significantly since reestablishing his relationship with his estranged sister. He agreed he could reach out to her if he felt suicidal. This was in contrast to his mood in the previous session two weeks before. He was discharged from the service, given information about private counselling should he need it and his GP informed.

In November 2012 he was again reported missing after an altercation with his wife. She advised her GP that he had been verbally abusive and thrown a plate at her. On returning home he stated he had had an epileptic seizure and taken himself to Accident and Emergency.

In 2013 and 2014 his wife expressed concerns about his memory loss. He was subsequently diagnosed with a Transient Ischemic Attack (TIA) which was felt to explain the memory loss. In

November Mr. McKenzie consulted his GP and described loss of balance when walking which was affecting his work as a network services engineer.

In 2015 he was admitted to A and E with chest pains, diagnosed as a result of stress.

9.2 2016

In October 2016 Mrs. McKenzie was diagnosed with acute kidney failure and advised by her GP that she needed to be admitted to hospital. She declined on three occasions. She was deemed to have mental capacity to decline treatment. However, two weeks later she was admitted to Calderdale and Huddersfield NHS Trust via the emergency department with loss of appetite, reduced mobility and poor fluid intake. Concerns were recorded in respect of pressure damage and malnutrition; her teeth and mouth care were poor. A staff nurse at the hospital observed that Community Nurses visited weekly to change dressings for leg ulcers and that she was surprised that they had not made a referral for any help. Mr. McKenzie indicated that he needed support as her carer and a safeguarding referral was made. Her presentation indicated a level of self-neglect and difficulty in maintaining personal hygiene. Adult Social Care determined that a care assessment was the appropriate pathway. Mrs. McKenzie was discharged home on December 2nd with a package of care funded by NHS Continuing Health Care (CHC) involving two 30-minute visits every day. There was a poor prognosis, and it was felt this may be palliative care.

Mr. McKenzie was referred to neurology after he injured himself trying to prevent his wife falling from a chair. This was diagnosed later as having an old fracture in his back probably from the fall and severe spinal stenosis. He declined further intervention. Partial medication compliance was noted at his annual epilepsy review. He advised that he forgets to take his medication because he is looking after his wife.

9.3 2017-18

Mrs. McKenzie’s health improved somewhat unexpectedly and from May 2017 she was under the care of community nurses for wound care. At first this was for two visits per day, but this reduced to one per day in September 2018. She had total bed rest for 18 months which enabled her legs to heal. She was then able to get out of bed and spend time sitting or in a wheelchair, but her legs deteriorated again. Compression bandages were the recommended treatment for her long-standing leg ulcers and lymphoedema, but Mrs. McKenzie was unable to tolerate compression therapy even when reduced compression was applied. She also chose not to comply with other professional advice to promote wound healing, e.g. bed rest in the afternoon and elevation of her legs. She was assessed to have mental capacity to decline recommended treatment and understood that poor wound healing could lead to risk of infection and sepsis. Mr. McKenzie was noted to be a supportive carer on a full-time basis. No concerns were raised regarding their relationship or domestic abuse.

In May 2017 Mr. McKenzie had expressed that his carer duties were causing stress – he was signposted to Carers Count[3]. He reported that he had forgotten to attend an appointment with the practice nurse for a medication review.

9.4 2019-20

Eligibility for CHC funding ceased in May 2019 and a new care package with the same provider was commissioned by Adult Social Care. Mrs. McKenzie began to cancel visits at home by community nurses and to attend the GP practice. She was reliant upon her husband to take her there in her wheelchair by bus. In August she again declined hospital admission for intravenous antibiotics to treat evolving cellulitis. In September the care package was reduced from two carers to one for 15 minutes each day to assist Mrs. McKenzie in personal care and to transfer to her wheelchair. In June 2020 Mr. McKenzie informed the surgery that he was struggling to bring his wife twice weekly. In August he stated that he was physically exhausted from bringing her to the surgery twice a week. It was felt that Mrs. McKenzie required to be seen twice per week and was still not complying with the leg dressing treatment. A referral to community nursing was not accepted as the criteria for accessing the community nursing service was that the patient should be housebound. At a multi-disciplinary meeting of the GP practice Mrs. McKenzie's behaviour was described as 'borderline negligent'. There was also a comment that 'she seems sad as if she doesn't want to get better'.

In January 2020 Mr. McKenzie was seen in the Huddersfield Royal Infirmary Emergency Department. He stated that he had injured an ankle moving his wife into her wheelchair. He later advised a nurse at the GP practice that he was feeling dizzy and losing his balance intermittently. He acknowledged an element of lack of self-care because of the needs of his wife. A good physical plan of investigations was put in place but there were no discussions/professional curiosity exercised to enquire about his home circumstances. The dizzy spells continued at the end of the year and a moderate fragility flag was placed on his GP records. In November 2020 during covid-19 the care package was suspended as Mrs. and Mr. McKenzie did not want visitors to the house.

9.5 2021

In January 2021 Mr. McKenzie consulted his GP as his hands had started to become numb. An essential tremor was noted with a plan to take blood tests and then referral to neurology. He did not attend for blood tests. He had commented that he felt the symptoms in his hands were getting worse because he was caring full time for his wife. In February the couple agreed that the care package be terminated as they had not received care for several months.

Throughout 2021 there was a pattern of attendance at and cancellation of appointments for leg dressings. Mrs. McKenzie attributed this in part to the difficulty of her husband bringing her to the surgery when he was not in good health. In July 2021 she was warned by her GP that she may be removed from the practice list if she continued to not comply with the treatment of her legs. Mr. McKenzie's details were updated to the effect that he was a carer for a person with a physical disability who was wheelchair bound. At the same time it was suggested to him that he

[3] Carers Count is a not-for-profit organisation that supports unpaid carers within Kirklees

make an appointment to complete a carer's review. He did not do so. The pattern of engagement and non-attendance at appointments continued for some months and into 2022, with Mrs. McKenzie frequently citing her husband's health as the reason for her not being able to attend.

9.6 June-December 2022

In June Mrs McKenzie first mentioned the difficulty with Mr. McKenzie's dementia. Although she was not defined as housebound the GP Practice and Community Nursing agreed a shared care approach with Mrs. McKenzie attending the GP practice one day and then being visited at home on another day in the week. This was good practice although the bulk of contact was by community nursing as Mrs. McKenzie contacted them frequently requesting home visits.

In July Mr. McKenzie attended for a 6CIT test [4].. He was reported to have had a one year history of forgetting who his wife was and general items around the house. Neighbours also recalled occasions when he wandered away from the house and was once found near the motorway. He scored 21 on the test leading to a referral to the memory clinic. His wife also reported that he needed hearing aids. She stated that his mood was fine now compared with when he received IAPT counselling in 2012. In August she contacted the Locala SPOC requesting a home visit as she was unable to leave the house, now describing herself as the primary carer for her husband.

During the period from September until December onwards Mr. McKenzie's behaviour became characterised by aggression, frustration and not recognising his wife. The Police were called to the house in early September. The chronology and circumstances surrounding the risk of harm to Mrs. McKenzie are described in detail in section 17. A discussion with a social worker was held re: assistance with shopping. Mrs McKenzie requested a carers assessment but a manager in ASC felt that a Care Act assessment would be more appropriate. Contacts with ASC focussed upon Mrs. McKenzie's mobility, the equipment in place to support her, abilities in daily living and self-care tasks. Contact was made with Age UK concerning the position of the ramp at their home. Regular home visits were being made by community nurses to attend to her leg dressings with a referral to tissue viability nursing. She declined a doppler assessment[5].

In October an Initial assessment and support plan was completed by ASC, outlining that Mr. McKenzie needed 1-1 social interaction to enable inclusion and provide a break for his wife. He did not want to go out to day care services and was assessed as having mental capacity to understand his needs. Following the ASC assessment a care package for Mr. McKenzie was commissioned from Nova Care of daily visits for one hour to enable social inclusion and opportunities for shopping. Later in the month he was assessed by the Memory service following a CT scan which showed small vessel chronic ischaemia with background brain atrophy. He was diagnosed with dementia in Alzheimers disease with late onset. He was discharged to his GP and referred to the Dementia Hub.

A home visit by Community Nursing in early November noted Mrs. McKenzie's steady weight. She reported that she eats well, has a stairlift in place, allowing her sleep in bed at night whilst

[4] The Six -item Cognitive Impairment Test is a dementia screening tool which gives a weighted score based upon patients' responses to questions. A score of 21 out of a possible 28 would be considered significant.
[5] A doppler test is used to detect whether there is adequate blood flow to a limb.

being out all day in a chair. It was planned that the Ageing Well matron would visit to assess safeguarding concerns regarding her husband's behaviour, but the visit did not take place. ASC conducted a carers led assessment by phone. Mrs. McKenzie stated that everything was on an even keel now that a care package was in place for her husband. She felt that no further intervention by ASC was required. Throughout November frequent requests were made for visits by Community Nurses concerning leg dressings.

In early December Mrs. McKenzie died after being assaulted by her husband. She was 69 years old, Mr. McKenzie 72.

9.7 Neighbours accounts

There were two neighbours who had lived close by Mrs. and Mr. McKenzie for many years who provided support to them. They described how prior to the impact of dementia Mr. McKenzie had been a quiet and reserved man. As his memory began to fail there were a number of occasions when he would wander far from home. One neighbour described an occasion when he was found some miles away on a dual carriageway near the motorway, another time he had walked for four hours and been found in the middle of the road crying.

Mrs. M., who was a particular friend of Mrs. McKenzie, noted how his behaviour deteriorated from May 2022. He could become aggressive and agitated. She believed that on the occasions when he did not recognise her Mrs. McKenzie was scared of her husband. He felt his wife was turning into a stranger. He would ask who she thought she was and told both neighbours that he did not know he had a wife at home. He often thought there was someone else in the house. Her own husband advised her to be careful when visiting the couple. Mrs. McKenzie had expressed a view that although she loved her home, she could not stay there and considered finding somewhere else to live.

Mrs. M. supported Mrs. McKenzie in September when agencies were contacted. She herself spoke to Gateway To Care (GTC) and explained the situation. After a week went by she phoned again as there had been no response. She was concerned that, although there were frequent visitors to the house, professionals did not pick up on what was happening.

On 7/12 Mr. McKenzie came to her house and told her that there was a strange woman in the house and that he had locked her in. He said the same thing on 8/12 and both neighbours had tried to calm him. Both neighbours became involved later that evening when Mrs. M. called the Police to report Mrs. McKenzie's death. Ultimately Mrs. M. stated that she was really shocked at Mrs. McKenzie's death but could see it coming, as in her view the couple did not receive the support they needed.

10 Analysis

This section addresses the key issues set out in the terms of reference.

10.1 Engagement with services/their care experience

Mrs. McKenzie was inconsistent in her engagement with services. In 2016 she repeatedly declined to be admitted to hospital in spite of considerable risks to her health from kidney failure. On discharge she did agree to a package of care and visits by community nurses, having total bed rest for 18 months. There then followed a long period of time up to her death when she required treatment for leg ulcers. She was frequently reviewed by the Tissue Viability Nurse and was also under the care of a vascular surgeon and lymphoedema nurse. From 15th June 2022 there was the shared care agreement between the GP practice and Community Nursing to carry out the treatment. On a number of occasions Mrs. McKenzie did not attend the GP surgery because she used a wheelchair and was dependent upon her husband to convey her. Her attendances became more difficult as his health declined so that her last attendance at the GP surgery was 19th August. The large part of the joint agreement was carried out by Locala Community Nurses home visiting. Mrs. McKenzie. frequently contacted the Locala SPOC to request or ask when visits taking place. But there was also a history of their telephone being unanswered and calls not returned.

Mrs. McKenzie was non-compliant with treatment for her leg ulcers, often tampering with or removing the leg dressings. There is evidence that the GP practice undertook mental capacity assessments, gave appropriate advice and assessed the risks arising from her poor engagement.

Mr McKenzie engaged with IAPT in 2012 and appears to have found the counselling sessions helpful. He was a regular attender at the GP surgery and sought help with medical conditions. It is clear that in 2016 he was frustrated with his wife and accused her of being selfish when she declined to go into hospital. He attended annual reviews of his epilepsy up until 2019 but was not seen at the practice from Jan 2021 until July 22. Following a decline in cognition engagement with him was difficult. He declined to use patient transport on one occasion and missed an appointment for a scan. His assessment by the memory team on 24/10 therefore took place at home.

Small support packages were put in place at different times for both Mr and Mrs McKenzie. In December 2016 an application had been made for a Care Phone but it is not clear if one was ever received. A care phone was requested again in September 2022. In November it was reported to Nova Care that Mrs. McKenzie had declined the care phone because of cost. There are other references to Mrs. McKenzie declining support because of cost. There is no evidence of her or her husband receiving advice about eligibility to claim benefits such as Attendance Allowance. Although referrals had been made to community plus and the carers trust, there are a number of examples of the couple being referred or signposted to resources which they then did not take up. It is doubtful that signposting was an effective way of enabling them to engage with services.

When the care package with Nova Care was put in place in October 2022 the couple engaged very well with the staff team. One hour per day each morning was made available primarily to enable Mr. McKenzie to access the community for a coffee and shopping. The support provided to him also had a clear benefit for his wife in relieving her for a short period of her caring responsibilities. Mr. McKenzie himself would often get ready and be awaiting staffs' arrival for his daily outing. At the practitioners meeting staff agreed that they were 'lovely people to care for'.

The agencies' engagement with Mrs and Mr. McKenzie would have been marked by a lack of continuity in personnel. The Community Nursing service had the most face-to-face contact with the couple, but Mrs. McKenzie was seen by 27 different members of Locala staff over 42 visits, as a result of national nursing workforce challenges exacerbated by the covid-19 pandemic. The staff present at the GP clinical meeting on 7/10/22 were different from those who took separate

decisions at the later PCHT meeting on 31/10/22. 4 different GPs were involved at various points between September and December 2022. Adult Social Care did not provide longer term involvement with the couple once Nova Care had been commissioned. Although this analysis may reflect the resource pressures on agencies and current methods of organisational working, Mrs. and Mr. McKenzie were a couple who could have benefitted from a key worker approach by any one of the agencies.

10.2 Indications of self-neglect

From 2010 onwards there were instances of Mrs. McKenzie declining treatment, e.g for high blood pressure, admission to hospital in 2016. When admitted to hospital in 2016 she showed clear signs of self-neglect. She was in a very unkempt and dirty state. The discharge letter to her GP indicated that for 3 months prior to admission she had been sitting on the sofa at home and not leaving the house. According to CHFT Mrs. McKenzie was assessed for care and support needs, a safeguarding referral sent at the time and reported verbally to Gateway To Care.

Mrs. McKenzie was explicitly clear that she did not want compression therapy even at the risk of sepsis. She was frequently non-compliant with her leg dressings for several years. She often pointed to the pain and discomfort of compression dressings as the reason why she did not follow the treatment advice. Staff attending the practitioners meeting expressed some sympathy with this view. The Tissue Viability Nurse indicated that non-concordance with compression bandage treatment is not uncommon due to the pain associated with it and that Mrs. McKenzie accepted the treatment that she was able to adhere to. It is recorded that she would not take antibiotics as they made her sick but had also declined anti-sickness medication. It is documented that she was considered ‘borderline negligent’ and there was a sense of frustration within the GP practice which was evident in the warning letter sent to her in July 2021, which advised that, if she did not comply with the treatment for her legs, she may not be able to continue as their patient.

Mr. McKenzie also at times acknowledged that his caring responsibilities were leading to neglect of his own needs, including not taking his epilepsy medication.

In approximately 2019 Mrs. McKenzie purchased a second-hand mobility scooter. This could have assisted her greatly with her mobility and reduced some of the physical toll on her husband from pushing her in her wheelchair. However her neighbour reported that she lacked the confidence to learn how to use it. During 2022 there were issues concerning the couple’s declining services such as Age UK cleaning service due to affordability. It is not clear if any agency recognised or tried to explore in more detail why the couple often chose to decline services.

In 2022 staff from Nova Care reported that the couple’s meals were being managed, there was support from neighbours and Mr. McKenzie was managing all personal care without concern. On the one occasion that the Police visited officers reported that the house was clean and tidy and in good repair. Both parties looked physically well and appropriately dressed. This observation was supported by her neighbours.

Mrs. McKenzie’s physical and medical issues were therefore the principal indicators of potential self-neglect in 2022. Although she was assessed to have mental capacity to decline treatment, there were missed opportunities to explore in more detail the potential self-neglect/safeguarding concerns shown by aspects of her behaviour and to understand these in conjunction with the

history of self-neglect recorded in 2016. There is no indication that the KSAB Self-Neglect Policy and Procedures - -where she could have been assessed as at high risk in the well-being and medication domain - had been considered in respect of either party. Practitioners expressed some confusion as to whether someone should be classified as experiencing self-neglect if they have mental capacity and fully understand the implications of not accepting treatment. This is an issue which should be clarified within the procedures and subsequent training.

10.3 Support for either party as a carer

Few positive steps were taken to support either party specifically as carers until a care package was agreed for Mr. McKenzie in October 2022.

Mr. McKenzie had asked for support in caring for his wife during her 2016 hospital admission. She was initially reluctant to consent for support but later agreed prior to discharge. In 2017 he was signposted to Carers Count when he stated that his carer duties were causing him stress, but he did not take this up. In 2019 at the review of Mrs. McKenzie's care needs, the level of dependence on Mr. McKenzie as a family carer was noted.

Mrs McKenzie's GP records were twice coded as 'temporarily housebound', the second occasion in August 2020 when Mr. McKenzie indicated that he was physically exhausted from taking her to the surgery in her wheelchair. When referrals by the GP practice to Community Nursing for home visits were rejected, there was no evidence of wider exploration of other options to support them attend appointments when they were struggling to do so. In November the small care package for Mrs. McKenzie had been suspended. In January 2021 Mr. McKenzie again consulted his GP in relation to physical stresses which he attributed to caring for his wife. This was a missed opportunity to look more widely at his needs as a carer, particularly as he had a history of back pain and a moderate fragility flag had recently been placed on his records. In July 2021 a member of the nursing staff suggested to Mr. McKenzie the need for a carer's review, but the onus on organising this was left to him and this was not completed, although there was a flag on his records indicating he was a carer for his wife. The GP practice referred Mrs. McKenzie to social prescribing (which she declined) and to a care coordinator for an electric wheelchair, but there is no evidence of any wider exploration of the impact of his carer role upon Mr. McKenzie's own health.

Much of the documentation regarding their continued struggles to attend the leg dressing appointments was held in Mrs McKenzie's medical records but not that of her husband. It was therefore difficult to correlate this information with his own health problems. This was also relevant to the risks of domestic abuse she faced, which are discussed in section 17.

There was minimal reference to caring responsibilities in Community Nursing records. No professional curiosity was demonstrated when Mrs. McKenzie regularly stated that her husband was unable to take her to appointments. An earlier discussion could have been held between Practice Nurses and Community Nurses about the expectation of Mr McKenzie. continuing to take his wife to the surgery. The shared care agreement began in June 2022 a short time before he was referred to the memory clinic and not reviewed thereafter.

Around this time there was a reversal of roles as Mrs. McKenzie needed to take more care of her husband. She was not initially recognised as being a carer for him when he was referred for assessment to the memory service. The memory service in its discharge report to the GP noted that Mrs. McKenzie was entitled to a carer's assessment. Mrs. McKenzie had been referred to

GTC by a neighbour in September 2022 and had herself requested a carer's assessment. It was after the home visit in October that a care package was put in place for Mr. McKenzie which also benefitted her. However on 4/11 social work support was discontinued following a telephone interview when Mrs. McKenzie stated that further assistance was not needed now that the care package was in place. As a carer of a family member with dementia she should have been offered 'an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.'[6] Any plan should have taken account of the fact that she was a wheelchair user with her own specific health needs and to some extent still depended upon support from her husband for a variety of daily living activities.

10.4 Impact of Covid-19 – relevant period March 2020-March 2021

At a review of the care package in September 2019 prior to covid-19 Mrs. and Mr. McKenzie stated that they valued the daily visits and the social worker concluded that the package should remain in place as both appeared vulnerable and required oversight from care staff due to the previous concerns about Mrs. McKenzie's skin integrity. The review noted that the small package of care reduced the likelihood of carer breakdown and that, if Mr. McKenzie did not continue to support his wife as much as he did, the package would need to be increased considerably.

The support package was then suspended in November 2020 at the couple's request to avoid people visiting the home during the pandemic. In February 2021 the provider suggested that it was no longer required and in a telephone call from ASC Mrs. and Mr. McKenzie agreed. In the interim period they had consulted their GP as Mr. McKenzie was experiencing dizziness and numbness in his hands. He was concerned that this was affecting his carer role. This was a missed opportunity to clarify whether community nurses were still visiting, how Mr. McKenzie as a carer was coping without support and how Mrs McKenzie was managing her personal care given previous concerns re: self-neglect in 2016. It was one of a number of occasions, not just during the covid period, when assurances given over the telephone that help was not required were accepted without more detailed exploration.

There is no indication that covid 19 impacted specifically upon their own relationship. However, Mr McKenzie was still struggling to bring his wife to the surgery twice a week, which inevitably would have increased their risk of infection when using public transport.

Mr McKenzie was not seen for his epilepsy annual health review from 2020 onwards. NHS England suspended the requirement for annual health reviews for long term conditions at beginning of the pandemic.

Workforce challenges during the pandemic led the Community Nursing Network to take a more stringent approach to home visiting. Pressures also meant that visits became very task-focussed and impacted by time constraints. This would have affected the capacity of

[6] Dementia: Support in Health and Social Care NICE quality standard QS6, quoted in National Collaborating Centre for Mental Health. The Dementia Care Pathway. Full implementation guidance. 2018

practitioners to exercise professional curiosity and build a relationship with Mrs McKenzie to address the element of self-neglect apparent in her behaviour.

Following his assessment by the memory service in October 2022 Mr. McKenzie was referred to the Dementia Hub. The hub has a wide range of services that would have been available to him. An introductory letter was sent to him promptly by the hub. However, at the time it was operating with a 9-12 week waiting list as a result of the covid pandemic. Consequently, by the time the letter was followed up by a telephone call in January 2023, Mr. McKenzie was in prison. It was possible for urgent referrals to be prioritised during this period, but in respect of Mr. McKenzie the memory service had assessed that there was 'no immediate risk'.

10.5 Evidence/indications of domestic abuse

In 2012 disclosures were made to IAPT, some inadvertent. Mr. McKenzie shared that he was having relationship difficulties and recounted a challenging childhood whereby his father was emotionally abusive to him. He then compared his behaviour to the same. This could have raised some concern around domestic abuse at the time.

Further there had been a disclosure to a GP in 2012 concerning Mr. McKenzie being verbally abusive and throwing a plate at this wife. She did not want any action taken. At this time no guidance on domestic abuse was available for GP practices to refer to and neither disclosure led to any further action.

There were no further references to potential domestic abuse until 2022. The following table, extracted from the full chronology, is a summary of occasions from September 2022 when agencies became aware of concerns that Mr. McKenzie may pose a risk of harm to his wife and actions taken in response.

Date	Event
04/09/2022	999 call from Mrs. McKenzie reporting she had been assaulted by her husband. He had pushed her following an argument over preparation of lunch. Mrs. McKenzie engaged with Police when two officers attended, stating she did not want formal Police action taken against her husband but did want to receive additional help with his care. She was well supported by neighbours one of whom took Mr. McKenzie to their house. Mrs. McKenzie said she was not afraid of her husband and would contact Police again if concerned for her safety. She stated that this was first time an incident of this kind had happened. DASH was completed. Graded Standard risk. No previous history recorded of domestic abuse or violence. Public Protection Notice (PPN) completed and sent to ASC. When there was no initial response from ASC the Police followed up and resent the notice on 15/9.
05/09 – 06/09	TC from Mrs. McKenzie to GP practice. Mr. McKenzie. had left the house and started walking. Police found him and returned him home. Reported by wife to be in an up and down mood, swearing without reason and angry. GP had a telephone consultation with Mrs. McKenzie Gave advice to try to lock doors, keep husband safe and if any problem call back. To await memory clinic appointment. 'Safety netted'.

Date	Event
06/09	Neighbour called GP practice. Mr. McKenzie is becoming very violent and abusive to his wife. She advised that the Police had been called. Appointment for telephone call made with Mrs. McKenzie for 23/09.
06/09	TC to Gateway to Care from Mrs. McKenzie and neighbour requesting urgent support. Reported that Mr. McKenzie is becoming extremely violent to her. Has previously tried to tip her out of her wheelchair. Has tried to kick his way out of the property.
07/09	Mr. McKenzie did not attend appointment for CT scan. Declined to go in transport. The memory team spoke to wife at length about ongoing challenges, including that he could be argumentative and that she sometimes found it difficult to manage his behaviours. Decision made to discuss at the Memory service MDT. Advice given to Mrs. McKenzie and neighbour to contact GP if needs changed or risk increased. Outcome of MDT was that GP be asked to treat any physical conditions before the memory team could accurately assess Mr. McKenzie.
09/09	Social worker made first phone contact with Mrs. McKenzie She stated she will contact Police if she feels at risk of harm as she has done in the past and that everything is fine and there are no concerns at this time. No discussion re: possible safeguarding referral.
13/09	Referral from Ambulance Service made on 07/09, opened and actioned by ASC . Call handler had reported hearing arguments and Mr. McKenzie saying he was scared ambulance staff would beat him up. Information passed to social worker.
16/09	Two contacts made by Mrs. McKenzie to social worker. Stated she would like someone to come in daily. Mr. McKenzie thinks there are two men in the home stopping him from leaving. Disclosed that husband has dementia and that his aggressive behaviour is variable.
27/09	Home visit by Locala for wound care. Mrs. McKenzie informed Community Nurse that she phoned Police last night due to her husband being aggressive. (This has not been confirmed by the Police.) He came downstairs in the night and was trying to push her out of the door. When asked she said he is normally ok but can be scary when he has episodes of aggression. Options discussed with her – e.g. care home, assisted living. Community Nurse shared the information with GP practice and ASC. Front door team stated they have received complaints about husband's aggression before. Locala Safeguarding team to progress introduction of significant events template. Social worker spoke to memory service and GP who had requested urgent home visit the following day, including attention being paid to Mr. McKenzie's mental health.
28/09	Home visit by Advanced Nurse Practitioner (ANP). Saw the couple together. Discussion re Mr. McKenzie's driving and care needs. Plan to discuss at clinical meeting and PHCT meeting and consider safeguarding referral.

Date	Event
29/09	TC by Social worker. Discussion re daily living and self care tasks. Care home and day care considered but Mrs. McKenzie would not want former. Home visit arranged for 3/10
03/10	Mrs. McKenzie reluctant to allow entry to social worker as husband in bad mood. She persisted, had discussion with Mr. McKenzie about mobility and memory loss. He did not want to attend a day centre and did not recall any altercation with his wife. Plan - complete paperwork for social inclusion by home care service and arrange shopping service.
04/10	PPN of 04/09 actioned by Gateway To Care front door.
06/10	TC to Mrs. McKenzie from social worker to discuss Public Protection Notice (PPN). This is the first reference to the Police call-out on 4/9. Mrs. McKenzie stated that her husband does not recognise her.
07/10	GP discussion in clinical meeting. Safeguarding referral to be made. TC to Gateway To Care to make referral abandoned because of long wait. Entry on 14/10 indicates awaiting call back from GTC.
21/10	Nova Care commissioned to deliver care package, made home visit for pre-assessment with couple. Mrs. McKenzie. advised care phone had been taken away from her. (Records suggest that the phone may have been returned at an earlier date because of financial issues.) Needs this in case of emergencies. Risk assessment created with regard to possible frustrations from Mr. McKenzie
24/10	Home visit for assessment by memory service. Diagnosis of late onset Alzheimers. No safeguarding issues identified. Practitioner spoke to Mrs. McKenzie alone re domestic situation while husband was out. Mr. McKenzie reported that he sometimes thinks there are two of his wife in the house or does not recognise she is there. Discharged on 26/10. Discharge letter gave no indication of any immediate risks identified.
29/10	Nova Care record that Mr. McKenzie. anxious and unsure if he had upset neighbours. Additions added to risk assessment ‘concerning his paranoia and how he feels’.
31/10	Discussed again in PHCT meeting. Potential safeguarding issue identified with Mr. McKenzie who has worsening dementia. Community Matron will visit both
4/11	ASC – carers led assessment by telephone. Mrs. McKenzie expressed things were on even keel with her husband at present. Felt no further intervention from ASC required at the moment following the introduction of the care package.
14/11	Nova Care report that Mr. McKenzie expressed paranoia about staff and his wife conspiring against him and others talking behind his back. No physical or frustrated behaviours
5/12	Nova Care advised by Mrs. McKenzie that Mr. McKenzie had been verbally aggressive towards her and had thrown away his meal. Discussion about rearranging calls to support her.

Date	Event
7/12	11.06 Nova Care advise ASC that Mr. McKenzie had tried to drag his wife outside in her wheelchair as he was kicking her out and had had enough. Had become increasingly aggressive towards her in the last few days. Nova Care advised to contact GP to explore whether this aggression caused by a possible infection. Mrs. McKenzie expresses she is frightened as no longer has a care phone. Nova Care increased welfare checks to double staffing because of possible aggression. 13.14 Nurse at GP practice spoke to Mrs. McKenzie 15.27 Nurse made referral to Admiral nurses. Plans to send urine sample and treat. Locality hub manager requested an assessor contact Nova Care for update on antibiotics and speak with Mrs. McKenzie in relation to a care phone given current risks.
8/12	Discussion between Nova Care and ASC re: difficulty of obtaining urine sample from Mr. McKenzie who is calmer today. Nova Care concern more for Mrs. McKenzie as he shows no aggression towards care staff. 13.26 Nova Care discussion with duty social worker on concerns raised and need for urgent support. Social Worker to speak to GP to try to organise a home call, look at whether sectioning may be required for safety and medication support. Nova Care advised GP declined to attend. Staff member to obtain urine pot and take to house. Mr. McKenzie in brighter mood but still confused, more than usual. Mrs. McKenzie will ring staff when sample ready and staff will take to GP Practice. 22.47 Police received call from neighbour to advise that Mr. McKenzie stated he had killed Mrs. McKenzie.

11 Commentary on individual agency responses

11.1 Police

The Police call out on 4/9 was properly responded to and recorded as a domestic assault. It was a proportionate response in the light of Mrs. McKenzie's wishes. It was good practice to talk to Mrs. McKenzie's neighbours but unclear whether officers also talked to Mr. McKenzie at the time. Neighbours confirmed that Mr. McKenzie's behaviour was deteriorating but the Police were not told of any other previous assaults. An appropriate PPN was sent to ASC to alert them to Mrs. McKenzie's need for more support. The follow up of the non-receipt of PPN was also good practice. No agency referred back to the Police when subsequent disclosures of potential abuse were made.

11.2 GP practice

The response by the GP to Mrs. McKenzie on 6/9 only focused upon how to manage her husband's wandering. There was no advice given concerning her own safety. Advice to lock doors was inappropriate given also that she was a wheelchair user and could not easily escape a risky situation. Following receipt of the neighbour's concern, including identifying that the Police had been involved, there should have been a same day or next day response instead of a telephone call 13 days later. A more prompt response could also have led to a referral to GTC for care and support.

On 23/9 the date of the telephone appointment the GP was unable to contact Mrs. McKenzie Taking account of previous information recorded, a potential safeguarding concern was noted. An Advanced Nurse Practitioner was tasked to undertake a home visit and speak to Mrs. McKenzie separately and to her neighbour. 'Also husband's MH issues being sorted'.[7] This was a more appropriate response, recognising the need to provide Mrs. McKenzie with an opportunity to speak confidentially.

At the visit on 28/9 the ANP was told of an 'increasing number of violent outbursts and that Mr. McKenzie can't remember them afterwards'. It is unclear if Mrs. McKenzie was spoken to alone to check if she felt safe. The plan for a safeguarding referral was appropriate although there is no indication that this was discussed with her or her consent gained. It was documented for discussion at the Clinical Meeting and Primary Health Care Team meeting.

The discussion at the GP practice clinical meeting on 7/10 was held over a week later. It led to a decision to make a safeguarding referral. The West Yorkshire Safeguarding Adults Policy and Procedures stipulate that concerns should be reported within 24 hours. In the event the referral was never followed through after initial difficulty in making a telephone call to GTC. The last entry on 14/10 states that the Practice was awaiting a call back from Gateway To Care. The ASC IMR does not record a safeguarding referral being received. This was a significant missed opportunity. Health staff were not aware of the contents of the Police PPN but had previously been told of Police involvement. Contact could have been made with the Police at this point to share and receive information.

On 13/10 a GP discussed the outcome of Mr. McKenzie's CT scan with his wife. There does not appear to have been any reference back to any of the safety issues that had been discussed at the clinical meeting.

There was a second discussion in the Primary Health Care meeting on 31/10. Although the attendees were different no account was taken of the previous decision three weeks earlier to make a safeguarding referral. The planned visit by the Community Matron did not take place because she was subsequently redeployed due to staff shortages. This represents a second missed opportunity to focus on safety issues for Mrs. McKenzie and to coordinate with other agencies via a safeguarding meeting. There is no indication that any other action was taken to compensate for the home visit not going ahead.

In December there again appears to have been a delay in responding to concerns for Mrs. McKenzie's safety. On 7/12 a referral to Admiral nurses was made in response to Mrs. McKenzie contacting the surgery concerned about her husband's aggression. This was a

[7] Quotation from GP Safeguarding Plan 27/09/22

positive response. Action was taken to seek to rule out an infection as a physical reason for aggressive behaviour, although there was ample information in health records to indicate that this was not an isolated occurrence. However this information may not have been held on Mr. McKenzie's file as concerns about violence from Mr. McKenzie were only entered in Mrs. McKenzie's records. Healthcare professionals working with him would not routinely have seen any of the earlier safeguarding concerns she had raised.

11.3 Locala

On 27/9 it was good practice by the Community Nurse to discuss options with Mrs. McKenzie and to pass on her concerns to the GP and ASC. A DASH could have been completed, although it was not unreasonable for the Community Nurse to have considered that either the GP or ASC would make a more detailed risk assessment. She also believed that the Police had been called the previous night. Locala stated that they were not advised of the outcome of the referral to ASC.

There is no evidence or potential indicators of domestic abuse being disclosed during home visits by Community Nurses other than on 27/9. Domestic abuse screening was not routine at this point as targeted enquiry was the expectation in accordance with NICE Domestic Abuse Quality Standard (QS116). Nonetheless the disclosures on 27/9 indicated that targeted enquiry should then have been followed and subsequent staff visiting should have been made aware of these concerns so that they could seek reassurance about Mrs. McKenzie's safety.

The staffing difficulties in the Community Nursing service outlined in 16.6 illustrate a number of factors. The persistence in delivering a service to Mrs. McKenzie in spite of these constraints is commended. It is argued on the other hand that there were therefore 27 different opportunities to observe any indications of domestic abuse within the couple's relationship. Community Nurses provided the most frequent level of contact with Mrs. and Mr. McKenzie but the lack of continuity by all agencies did not enable the building of a relationship with Mrs. McKenzie This can be particularly important in developing productive work with people who self-neglect.

"Practice with people who self-neglect is more effective where practitioners:

Build rapport and trust – showing respect, empathy, persistence and continuity

Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience"[8]

11.4 Adult social care

It is of concern that the PPN from the Police and the information from the Ambulance Service were not acted upon more quickly. The ASC front door was slow to follow up and prioritise PPNs. It was reported by practitioners that the demand on the Adult Social Care front door is significant and that there is a backlog of emails.

[8] 'Working with people who self-neglect Research in Practice, updated 2020 by Suzy Braye and Michael Preston-Shoot

The phone call to Gateway To Care on 7/9 by Mrs. McKenzie and her neighbour described a more frequent incidence of aggressive behaviour than had been reported to the Police. Some form of risk assessment and enquiry about safety measures for Mrs. McKenzie could have begun at this point.

On her first telephone call on 9/9 the social worker appeared too accepting of Mrs. McKenzie's account, given what was known from the concerns expressed by neighbours. The original PPN from the Police had not been received at this point and the concerns from the ambulance service not acted upon. Nonetheless there was an opportunity to discuss with Mrs. McKenzie what safety measures or ability to summon assistance were in place or needed. Further contacts from Mrs. McKenzie four days later, when the ambulance service concerns had been registered and she disclosed a similar example of his paranoia, still did not lead to any consideration of safeguarding. Slow decision-making within ASC as to whether a Care Act or carers assessment was required meant that a home visit to see Mrs. and Mr. McKenzie face to face was not undertaken for several weeks. Arguably both assessments were needed.

On 3/10 the social worker showed good persistence in persuading Mrs. McKenzie to allow her entry and to have discussion with both parties. As she saw them together, she did not have an opportunity to talk to Mrs. McKenzie alone about safety issues. The PPN from the Police had still not been opened. This was discussed with her on 6/10. The plan outlined was to refer Mr. McKenzie for social inclusion support via a home care service, follow up the shopping service and refer to community plus. It is not clear how far issues of Mrs. McKenzie's safety were considered.

The Duty Front Door Urgent Initial Assessment and Support Plan prepared on 11/10 referred to the fact that Mr. McKenzie can be aggressive towards his wife 'due to demands place upon him'. It also referred to the fact that he does not always recognise his wife. There was no risk assessment in the care and support plan with which to evaluate the seriousness of the risk nor how it should be managed. It did not refer back to the content of the PPN and the risk assessment made by the Police in the DASH concerning domestic abuse.

Consequently when the care package for Mr. McKenzie was commissioned from Nova Care, the information concerning a risk of domestic violence was not accurately conveyed to the provider. Nova Care state that the referral they received was to help with social activities only and that they did not become aware of Mr. McKenzie's epilepsy until about 5 weeks after the care package had commenced.

The provision of a care phone for Mrs. McKenzie was never resolved and illustrates a lack of adequate recognition by the agencies of her vulnerability. A meeting triggered under safeguarding procedures could have explored in more detail what protection she required.

The decision by ASC on 4/11 to discontinue contact with Mrs. McKenzie came only four days after the PHCT meeting decided that a safeguarding referral may be necessary. This illustrates the lack of coordination by the agencies and the consequences of the GP surgery not following through its original decision to make a safeguarding referral. Adult Social Care report that there are now three access and information officers who have 'read only' access to a limited range of System 1 medical records.

11.5 Memory services (SWYFT)

Mrs. McKenzie and her neighbour discussed her husband by telephone with the Memory Service in September and advised that she was struggling to manage his agitation and

argumentative behaviour. It is not clear if she told them of the Police callout. (The original referral to the memory service pre-dated the Police callout. Following triage the GP was asked to undertake tests to rule out any physical cause of memory loss. It appears that the referral may not have been updated to include reference to the Police involvement and conversations with Mrs. McKenzie in September.)

When a home visit was made on 24/10 Mr. McKenzie was out. The practitioner took the opportunity to talk to Mrs. McKenzie about the domestic situation without her husband present. No domestic abuse concerns were disclosed. Mrs. McKenzie felt that everything was going well because of the care package even though this had only begun three days earlier. This contact shows a pattern of Mrs. McKenzie understating her concerns at different points to professionals and her assurances being accepted at face value without any corroboration or cross-referencing. Although the practitioner approached the interview mindful of the need to consider potential domestic abuse, they either did not have or did not refer to the information about the Police call out and the history of aggression that had been reported to the GP and ASC.

The discharge letter to Mr. McKenzie's GP made reference to his counselling at IAPT, describing this as for low level depression. There is no more detail about the content of the sessions which often focussed upon relationship difficulties with his wife and his concerns that he may hurt her.

There was consideration of medication to alleviate Mr. McKenzie's memory loss, but this was declined by Mrs. and Mr. McKenzie because of the risk that it may increase the incidence of seizures.

The SAR into the death of Mr. F. recommended that families must have easy access to an identified lead professional. The discharge report states in bold that Mrs. McKenzie was entitled to a carers assessment. It is not clear to whom this was addressed. Referral was made to the Dementia Hub and the couple were provided with information concerning Admiral Nurses, but there was no nominated lead professional to support the couple at this time.

11.6 Nova care

Nova Care staff discussed with Mrs. McKenzie strategies for helping to calm Mr. McKenzie when he became frustrated and on 7/12 took action promptly to advise adult social care safeguarding of the risk of domestic violence. They contacted Mrs. McKenzie on several occasions to check up on her safety and try to obtain the sample from Mr. McKenzie that had been requested. Their contact with the GP practice did not appear to lead to any increased urgency in spite of the earlier call from Mrs. McKenzie herself and the concerns being raised by the provider.

11.7 Multi-agency working

The only risk assessments evident are the DASH completed by the Police and that within the hospital passport prepared by Nova Care after their pre-assessment meeting. The information received by the Police was incomplete and led the officers to believe that they were attending an isolated incident. The assessment by Nova Care focused upon how Mr. McKenzie handled his frustration, stating that 'he can become very agitated and will often take himself away to his room and lay down until the feelings pass.' Mrs. McKenzie's strategy is to leave him to relax and

manoeuvre away from him. Staff were advised not to confront him. Nova Care had not been informed of the earlier Police call out. If the provider had received more detailed information about the potential risk of aggression towards Mrs. McKenzie, their assessment and management plan could have been more thorough from the outset. However, as they got to know the couple better, staff began to recognise the risks to Mrs. McKenzie, including aspects of coercion and controlling behaviour. For example when Mr. McKenzie was in a low mood he would place items such as the TV remote and phone out of reach of his wife from her wheelchair and go upstairs to bed until he felt better. However this information was not recognised by staff as a possible indicator of domestic abuse and only made known during the course of this review.

There was a clear need for a multi-agency safeguarding meeting to share information, consider appropriate safety plans for Mrs. McKenzie and review the care provided for her husband. Although a safeguarding concern was recognised on two occasions by the GP practice, the referral to ASC was not followed through. There was information provided to the GP practice and ASC by Mrs. McKenzie herself and neighbours concerning fears for her safety, but these concerns appear to have been rarely communicated to other practitioners making home visits. The absence of a multi-agency risk assessment was critical. Staff all felt that they were a lovely couple to care for and consequently did not look more deeply at what was known about Mr. McKenzie's behaviour. Neighbours on the other hand were frustrated that the concerns they expressed to professionals were not given due weight. Whilst the death of Mrs. McKenzie may not have been predictable, there was information available that showed Mr. McKenzie presented a risk of harm to his wife.

When he was discharged from the memory team the plan outlined for Mr. McKenzie contained no actions other than information-giving and referral to the Dementia Hub, which at the time had a 9-12 week delay in processing referrals. There was no specific support offered to Mrs. McKenzie as a carer of a person with dementia, including someone showing episodes of aggression and frustration. 'It is important that a coordinated care plan that covers aspects of supporting well, living well and dying well is developed and agreed jointly by the person, their family and/or carer, and their health and social care professionals team'.[9] There appears to be a need for greater clarity about which agency is responsible for developing a more comprehensive care plan in these circumstances.

Safeguarding procedures were not followed and there is no indication that the domestic abuse procedures were consulted. A meeting to share information could have resulted in a well-informed risk assessment and may have led professionals to connect the examples of Mr. McKenzie not recognising his wife and his paranoia about other people being in the house – the combination of perceptions by him that may have triggered the fatal attack on his wife. Although mental health issues are mentioned on several occasions, Mr. McKenzie was not referred for a Mental Health Assessment.

On two occasions staff explored the possibility of alternative options for Mr. McKenzie, such as a care home placement. Mrs. McKenzie did not wish to pursue these at the time because of the potential negative impact upon him. It is not clear if anyone discussed with Mrs. McKenzie whether she herself would want to leave the property apart from the community nurse on 27/9.

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[9] National Collaborating Centre for Mental Health. The Dementia Care Pathway. Full implementation guidance. p 21, 2018

Practitioners reported that there were few immediate resources for someone in Mrs. McKenzie's position other than a refuge or temporary bed and breakfast.

11.8 Good practice

There were elements of good practice at different times.

Mrs. McKenzie's non-compliance with treatment for her leg ulcers was a constant theme over several years. She also declined treatment at other points, including when she was close to death in 2016. Mental capacity assessments were undertaken and documented at these times to confirm that she had capacity to decline treatment and understood the potentially serious consequences.

A range of practical support and aids were provided to Mrs. McKenzie to address her lack of mobility, as well as the small support package that ran from 2017 until 2020.

Although under severe pressure as a result of staff shortages Community Nursing regularly attended when requested to support Mrs. McKenzie with her leg dressings. The shared care agreement instituted by the GP practice and Locala took account of Mrs. McKenzie's difficulties in attending the GP surgery, although in practice Community Nursing took most responsibility as Mr. McKenzie's health declined.

There were examples of practitioners recognising the importance of speaking to Mrs. McKenzie alone concerning her wellbeing. The Community Nurse who visited the home on 27/9 took particular steps to alert the GP practice and ASC to the potential safety risks to her. Although the GP practice should have responded with more urgency when Mrs. McKenzie and her neighbours contacted them in early September, there was an appropriate safeguarding response when it was not possible to contact her by telephone on 23/9.

The support from Nova Care was clearly valued by Mrs. and Mr. McKenzie and staff took extra steps to check on her wellbeing on 7 and 8/12.

The Police made a reasoned risk assessment in the DASH given the information they elicited during their visit and had good systems in place to follow up PPN's when no response was received from ASC.

12 Conclusions

Mrs. McKenzie was a woman with significant health needs. She was a wheelchair user with limited mobility, although she could increasingly undertake tasks around the house. A number of practical measures were put in place to assist with her mobility, and she received regular support from Community Nurses. There was evidence of significant self-neglect in 2016 and to a lesser degree in her subsequent non-compliance with treatment for her leg ulcers. Both she and her husband had experienced traumatic episodes in their lives which may have had a lasting impact upon them.

Mr. McKenzie was a conscientious carer for five years until he experienced dementia. More attention should have been paid to the impact of his caring role upon his own physical health. The small care package received by his wife helped to prevent carer breakdown, but this was then discontinued during the pandemic and not reinstituted. On this and other occasions

assurances that all was well were accepted by telephone without sufficient professional curiosity being exercised to determine if this was really the case. Practitioners could have taken more account of Mrs. McKenzie's history of self-neglect and explored in more detail why the couple were often reluctant to take up resources available to them. This would have required spending more time with them face to face and it is not clear if this would have been possible during and following the pandemic even if the need had been recognised.

Although there were some earlier examples of Mr. McKenzie expressing thoughts of harming his wife and one reported incident ten years before, concerns for Mrs. McKenzie's safety coincided with the advancement of his dementia and the subsequent diagnosis of Alzheimers disease. His aggression towards his wife was not recognised as domestic abuse. As a result she was not provided with access to any domestic abuse resources that may have been available to her and the many professional staff who visited the home were not alerted to this risk. The dementia assessment and referral to the Dementia Hub did not appear to take full account of the difficulty Mrs. McKenzie was having in managing her husband's aggressive behaviour towards her. The care package put in place with Nova Care for her husband was helpful and welcomed by them but not sufficient to support her as a carer with her own vulnerabilities.

The response by agencies overall was uncoordinated with insufficient information sharing. Risk assessments were not completed. Apart from the initial response by the Police, safeguarding and domestic abuse policies and procedures were not followed.

13 Lessons to be learnt

13.1 Findings from reviews and publications

The Safer Lives 'Spotlight' publication on Safe Later Lives: Older people and domestic abuse[10] abuse highlighted the lack of recognition of domestic abuse by professionals working with older people. Its findings also reflected some of the issues present in this review.

'the caring dynamic can present difficulties when the individual being cared for becomes the perpetrator, perhaps due to medical issues that can exacerbate aggression such as dementia. In these situations the victim may feel a lot of guilt connected to any disclosure of the abuse….Similarly, when there are additional health issues present within an abusive relationship, it may lead to the professionals not suspecting domestic abuse because of the vulnerability of the perpetrator.'

In respect of Mrs. and Mr. McKenzie it was perhaps not the lack of recognition of abuse, but that the aggression towards her was not defined as domestic abuse.

A key finding of the Home Office analysis of DHR's October 2019-20 was that in one case "the victim would have benefitted from a carer's assessment, a structured support package and respite care. However many carers are reluctant to accept help for themselves and just want the person that they care for to receive the help they need." Mrs. McKenzie closed off other offers of

[10] Safe Later Lives :Older People and domestic abuse October 2016

help as soon as the care package from Nova Care was in place, reflecting also her own ambivalence at accepting help and at following guidance that was often present in the treatment of her legs.

Mrs. McKenzie at one point dismissed the option of a care home for her husband as she felt he would not tolerate it. This is not an unusual perspective in respect of couples who have shared a long marriage, in this case approximately 54 years, and particularly when one is a carer for another. A finding in a similar SAR prepared for Dorset Safeguarding Adults Board stated.

"Disincentives for older people who have been living with abuse over years to do something about it are many. These include attitudes and beliefs particularly around the role of women, financial dependency on their abuser , or preconceptions about their husband or partner's inability to manage, due to illness and dependency, without their care."[11]

In Mrs. McKenzie's case the abuse may not have been long-standing, but she may have been prepared at times to minimise her concerns to avoid further professional involvement. Although she mentioned in the letter to her cousin that she was intending to look for alternative accommodation, this plan would have posed a number of emotional and practical obstacles for her.

13.2 Learning from previous reviews – Kirklees Safeguarding adults board

A serious case review into the death of Mr. F., a man who suffered with multiple medical conditions including vascular dementia, made a number of recommendations also relevant to this review. These included

That agencies adhere to an agreed care pathway across Health and Social Care for anyone with dementia. (Rec. 3)

That agencies have mechanisms in place to ensure that carers and family are evidently and sensitively included by all professionals as partners in providing care and support. (Rec. 7)

Families must have easy access to an identified lead professional (Rec 8)

There is now a clear dementia pathway which was followed in respect of Mr. McKenzie's referral and diagnosis and is being updated.

Mrs. McKenzie was provided with a telephone consultation with the GP practice to explain the results of Mr. McKenzie's CT scan. Given the earlier difficulties experienced in Mr. McKenzie attending hospital for the scan, the Memory service made a home visit to undertake a face to face assessment. This was good practice recognising Mrs. McKenzie's own mobility issues and that she would feel more comfortable contributing to an assessment in her own home. The practitioner spent separate time with both parties.

There was no identified lead professional to support Mrs. McKenzie subsequently after Mr. McKenzie was discharged from the Memory Service.

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[11] Dorset Safeguarding Adults Board 'Katherine' October 2021

13.3 Learning from previous reviews – South West Yorkshire Partnership NHS Foundation Trust

Learning from four previous DHRs has identified the need for routine enquiry into domestic abuse. From October 2023 the Trust has recommended that all service users over the age of 16 are to be routinely asked if they are experiencing domestic abuse, ideally at initial contact if safe to do so or at a later point if appropriate. The routine questioning should form part of the ongoing assessment and should be re-visited throughout the service user's care.

The Trust has also become a member of the Triangle of Care membership scheme to promote long term commitment from mental health providers to keep carers and families of service users informed and supported.

13.4Vulnerable adults action meeting (VAAM)

The VAAM has been established since November 2021 to provide a consistent and timely response in respect of Public Protection Notices submitted to community health and social care by the Police. Its aims and key principles include:-

- To ensure that there is a consistent approach to central decision-making processes and
- To ensure that individuals are supported in line with the Local Authority's policy and procedures.
- To determine that individuals have the correct support around them
- Multi-agency information sharing to ensure risks are identified and a multi-agency approach to setting and achieving individuals' outcomes with the community.

PPN's that have multiple indicators are reviewed each week by the Police Chair and information sent to the relevant agencies that sit on the VAAM.

13.5General learning from this review

13.5.1 Recognition of domestic abuse behaviours in Alzheimers/dementia patients

Mr. McKenzie was variously described as agitated, frustrated and aggressive. It is recognised that 'more than 90% of people with dementia will experience behavioural and psychological difficulties. These include agitation and… aggression ' [12] Staff appeared unclear when such behaviours may constitute domestic abuse and require a safeguarding approach. It is also

[12] 'Dementia evidence for primary care in Kirklees' quotation taken from Dementia Hub web-site.

important to define such terms in detail in order to build an assessment of risk as each risk indicator needs to be weighted in respect of frequency and potential seriousness.

13.5.2 Professional curiosity

The Multi-Agency Safeguarding Adults Policy and Procedures define professional curiosity as 'the capacity and communication skill to explore and understand what is happening within a family or individual's' life rather than making assumptions or accepting things at face value'. A lack of professional curiosity has been identified multiple times in the agencies' IMRs. It is accepted that staff shortages, as experienced for example by Locala, can be a barrier. There were however other examples when a more reflective approach combined with better use of historical information held in agency files, could have led to better engagement with and by Mrs. and Mr. McKenzie.

13.5.3 Signposting

It has been observed in other reviews conducted by the author that, when individuals show potential signs of self-neglect or appear averse to accepting professional help, signposting is not an effective way to enable them to take up services or resources that they may need.

14 Recommendations

14.1 Recommendation 1

The aggression shown towards Mrs. McKenzie. was not identified as domestic abuse by practitioners or care providers. Older people experiencing domestic abuse may have different needs from other groups and may not be comfortable using resources such as refuges. When an individual is experiencing cognitive decline there is a risk that domestic abuse may not be suspected because of the vulnerability of the perpetrator.

14.1.1 Recommendation:

The Kirklees Communities Board should seek assurance from relevant agencies that a review of their training modules on Domestic Abuse and Older People takes place. This should include integration of specific learning from this review, in particular identifying the risk of domestic abuse in older people with cognitive decline. It should ensure that the learning has wide coverage across staff in all relevant organisations, including independent care providers.

14.2 Recommendation 2

At different times both Mrs. and Mr. McKenzie were carers for each other, but insufficient support was provided to them in this role.

14.2.1 Recommendation

The Kirklees Safeguarding Adults Board should work with partners to ensure that carers assessments are being undertaken and that support is offered to carers in a timely manner. This should include a review of where carer information is kept and disseminated and how individuals can be informed of how to request a carer's assessment.

14.3 Recommendation 3

Although Mrs. McKenzie had a history of self-neglect the self-neglect pathway was not used as a tool to assess and understand her non-compliance with treatment for her leg ulcers.

14.3.1 Recommendation

The Kirklees Safeguarding Adults Board should provide further guidance in how to respond to individuals with mental capacity who decline treatment for chronic health conditions and audit the outcomes of the revised self-neglect pathway.

14.4 Recommendation 4

Staff at Nova Care were not fully briefed about the risk to Mrs. McKenzie from her husband nor about his health conditions.

14.4.1 Recommendation

Adult Social Care and the Integrated Care Board should ensure that all commissioning agreements with independent care providers contain a risk assessment focussing on potential harm to the individual and, where relevant, from the individual to others.

14.5 Recommendation 5

Mrs. McKenzie had no identified key worker to support her in managing her husband's dementia following the dementia assessment. Although this was in part due to a backlog of casework in the Dementia Hub, access to services could have been prioritised if the risks posed by Mr. McKenzie's aggression and potential mental health difficulties had been recognised earlier.

14.5.1 Recommendation

The Kirklees Safeguarding Adults Board should revisit recommendation 8 of the SAR into Mr. F. to ensure that current arrangements (i) enable families and carers to have easy access to an identified professional/key worker and (ii) to determine whether a priority approach should be adopted for families and carers of patients who exhibit aggression

14.6 Recommendation 6

Although it was recognised by the GP practice that the criteria for a safeguarding referral had been met, this was not followed through when there were initial difficulties in contacting Gateway To Care.

14.6.1 Recommendation

The Kirklees Safeguarding Adults Board and Communities Board should seek assurance with evidence from individual agencies, including Primary Care, that safeguarding concerns are being referred to Adult Social Care within the timescales set out in the multi-agency procedures.

14.7 Recommendation 7

It was not possible for health practitioners to easily cross-reference entries in Mrs. McKenzie's medical records to that of her husband and vice-versa. It is recognised that this may also be an issue in other agencies.

14.7.1 Recommendation

The Kirklees Safeguarding Adults Board and Communities Board should seek assurance with evidence from individual agencies that processes are in place so that, where there is a safeguarding concern or domestic abuse, medical/client files of an individual can be cross referenced to those of other family members.

14.8 Recommendation 8

The VAAM has been introduced to highlight priority cases within PPNs and help to deal with the ongoing volume of demand.

14.8.1 Recommendation

West Yorkshire Police and Kirklees Adult Social Care should review the governance of and impact of the VAAM arrangements to ensure that all PPNs that have multiple indicators now receive an appropriate and timely response.

14.9 Recommendation 9

Locala community nurses were well positioned to have played a key role in identifying domestic abuse but a lack of information sharing and staff shortages combined to prevent a consistent response.

14.9.1 Recommendation

Locala should continue to address its staff shortages and ensure that community nurses have capacity and confidence to recognise and respond to domestic abuse.

14.10 Recommendation 10

Agencies in their IMRs set out a number of internal improvements they had made or intended to make. A need for staff to exercise professional curiosity was a common theme.

14.10.1 Recommendation

The Kirklees Safeguarding Adults Board and Communities Board should seek assurance and evidence from individual agencies regarding the embedding of key learning from this review and the completion of internal changes they planned to make as set out in their IMRs. This should include encouraging and enabling staff to develop professional curiosity as a casework skill.