Mental health law under review? Messages from English Safeguarding Adults Reviews

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Abstract

Purpose – The purpose of this study was to examine Safeguarding Adults Reviews (SARs) that refer to mental health legislation in order to contribute to the review of English mental health law (2018).

Design/methodology/approach – Searches of a variety of sources were conducted to compile a list of relevant SARs. These are summarised and their contexts assessed for what they reveal about the use or consideration of mental health legislation.

Findings – The interaction of the statutes under consideration, in particular the Mental Health Act 1983, the Mental Capacity Act 2005, together with the Care Act 2014, presents challenges to practitioners, and the efficacy of their application is variable.

Research limitations/implications – In light of the absence of a duty to report SARs to a national register it is possible that relevant SARs were missed in the search phase of this research, meaning that the results do not present a complete picture.

Practical implications – Examination of cases where use of legislative provisions in mental health has been found wanting or legislation may not be easily implemented may inform initiatives to increase understanding of the law in practice and improve legal guidance offered to practitioners.

Originality/value – This paper's originality and value lie in its focus on mental health legislation as discussed in SARs at a time when both the Mental Health Act 1983 and the Mental Capacity Act 2005 are the focus of attention for reform.

Keywords: England, mental health, Care Act 2014, Mental Health Act 1983, Mental Capacity Act 2005, Safeguarding Adults Reviews

Paper type: Research paper

Background

British Prime Minister Rt. Hon. Theresa May made explicit commitment to address problems of the United Kingdom's (UK) mental health services on her appointment (July 2016). She declared that there was 'not enough help at hand' for people with mental health problems. In 2017, following a General Election, she announced an independent review of the Mental Health Act 1983 to address the problems arising from 'discriminatory use of a law passed more than three decades ago' (Savage, 2017). The government subsequently appointed Professor Sir Simon Wessely to chair the review; a leading psychiatrist, a former President of the Royal College of Psychiatrists and President of the Royal Society of Medicine. The review was tasked with exploring how legislation (especially the Mental Health Act 1983 (MHA)) is currently used in England; its impact on service users, families and staff and to make recommendations to improve legislation and related practices (Department of Health (DH) and Rt. Hon. Theresa May, 2017). Specifically, the review team was asked to provide understanding of the reasons for: (a) rising rates of detention under the MHA;

(b) the disproportionate number of people from black and minority ethnic groups detained under the MHA; (c) any processes that are out of step with a modern mental health care system (DH, 2017). An interim report was produced in 2018 (Department of Health and Social Care, 2018a) and a final report, with detailed recommendations, was published in December 2018 (Wessley 2018). To inform the review team an analysis of English Safeguarding Adults Reviews (SARs) was undertaken in summer 2018 to provide a synthesis of messages from SARs relevant to the review's objectives. This paper reports the approach taken to the analysis which encompassed the SARs' contexts and their recommendations relevant to mental health legislation.

Under section 44 Care Act 2014 (applicable to England), a Safeguarding Adults Board (SAB) must arrange a SAR where there is reasonable cause for concern about how partner agencies have worked together to safeguard an adult with care and support needs in its area who has died as a result of abuse or neglect, whether known or suspected, or who is known or suspected to have experienced serious abuse or neglect. In addition to this new statutory duty, the Act also makes provision for SABs to arrange discretionary SARs in relation to any other case involving an adult in its area with care and support needs (section 44(4) Care Act 2014).

The declared overall purpose is to promote learning and improve practice, not to re-investigate or to apportion blame. General objectives include establishing:

- lessons that can be learned from how professionals and their agencies work together
- the effectiveness of local safeguarding procedures
- learning and good practice
- possible improvements to local inter-agency practice

- service improvement or development needs applicable to one or more service or agency.

The Care Act 2014 (section 43(5) and Schedule 2, para 4) requires that findings and action taken to implement the findings from a SAR are published in the SAB's Annual Report. While there is general guidance on their conduct (Department of Health and Social Care, 2018b; Social Care Institute for Excellence, 2015), many SABs have developed their own SAR policy and processes documentation, which is usually located on their websites. The variety of SARs echoes that of their predecessors, Adult Serious Case Reviews (SCRs), owing to the range of circumstances reviewed (the types of abuse or neglect, the location, the timescale and the context). This is because once the decision to commission a SAR has been taken its terms of reference are locally determined by the SAB and, as Preston-Shoot (2018) suggested, a review needs an '*understanding of both local geography and the national legal, policy and financial climate within which it sits'* (p. 78).

Context particularly matters in respect of the interface between mental health services and practice, and adult safeguarding. Whitelock (2009) considered that the (pre Care Act 2014) adult safeguarding system was failing many people with mental health problems who '*feel disempowered by and frustrated with a paternalistic system that labels them 'vulnerable' and fails to take account of their preferences in making decisions about their safety'* (p. 30). More recently, concern has been expressed that not only do people with mental health problems experience higher levels of criminal victimization than other adults (Pettit *et al*., 2013) but that '*The discourses on adult safeguarding and risk, mental health and 'disability hate crime' have appeared to remain largely separate in research, policy and practice, and overall, mental health service user experiences remain under-researched'* (Carr *et*

al., 2017). In their recent review of the literature on United Kingdom (UK) mental health service user experiences and perspectives on mental health-related targeted violence and hostility (often referred to as 'disability hate crime'), Carr *et al.* (2017) found: '*Adult safeguarding did not feature strongly in the findings about help-seeking behaviour and reporting'*.

Lastly, SARs, in which the safeguarding related aspects of mental health care and treatment for different parties may be scrutinised, are not the only system overview in England. Two are particularly pertinent to SARs. First, in 1994 a system of Mental Health Homicide Reviews was established, since 2013 termed Independent Investigations. NHS England is responsible for commissioning such investigations from independent expert organisations into homicides committed by patients being treated for mental illness. Their reports are available online.[1] Several provide detailed pictures of adult safeguarding and among some the investigatory team's membership has included adult safeguarding personnel (see, for example, the Mr X Investigation, NHS England, 2018, p. 26). The future may see the development of joint SARs and Independent Investigations, following the example of joint Domestic Homicide Reviews (established under section 9(3) of the Domestic Violence, Crime and Victims Act 2004) and Independent Investigations (see Hunter, 2017).

Second, are the investigations conducted by the Local Government and Social Care Ombudsman into complaints; which at times cover the application or misapplication of legal procedures. One recent report addressed the common findings related to complaints made about the use or misuse of mental capacity law in practice (Local Government and Social Care Ombudsman, 2017). The Ombudsman upheld several complaints on this subject, noting consistently reported problems of delays in

[1] https://www.england.nhs.uk/north/our-work/publications/ind-invest-reports/

conducting mental capacity assessments, poor decision making and failures to involve family members as the law requires. It noted the high proportion of complaints it received concerning the workings of the Mental Capacity Act 2005 and, in particular, the difficulties associated with operationalising the Deprivation of Liberty Safeguards (DoLS) where a mental health assessment is required to confirm the presence of a 'mental disorder' within the meaning of the Mental Health Act (ibid.). It acknowledged legal reform was being considered to address the problems of DoLS in practice within limited resources and changes to legal interpretation (ongoing at the time of writing – late-2018 – with the Mental Capacity (Amendment) Bill being before Parliament).

Methods

Building on our collection of SARs, we read each one to identify if their recommendations made reference to mental ill health (and similar terms) and specifically mental health law. We excluded reviews focusing on people with dementia because we have previously examined these as a discrete set (Manthorpe and Martineau, 2016). Our analysis had found that the key relevant statute reported as being overlooked was the Mental Capacity Act 2005 (MCA) in addition to variable practice (a view also maintained by the authors of SARs and SCRs where self-neglect was an issue – see, for example, Preston-Shoot, 2017a; 2018). Thus, while focusing on mental health law, specifically the Mental Health Act 1983 and Mental Health Act 2007, and including the Care Act 2014, we do not address the MCA other than tangentially. Though we were alert to the potential for other statutes to be mentioned our focus was on mental health law.

We supplemented our own collection with other emerging documents that have focused on SARs (e.g. Braye and Preston-Shoot's (2017a) analysis of 27 London

SARs; of which only eight had been published at the time of their report). We undertook internet searching of local authority sites and general search engines, by using the term 'Safeguarding Adults Review', to cross-reference the developing collection. In addition, we searched the library of Safeguarding Adults Reviews, presently (mid-2018) being developed by the Social Care Institute for Excellence and Research in Practice for Adults (Social Care Institute for Excellence, 2018) that built on our own collection. This contained 75 SARs at the time of writing, and we added to it those we had found in our other searches (taking the total to 95). We also consulted other collections and their syntheses, such as that compiled by Surrey County Council[2] and the overview of SARs (11 in number) and SCRs in South-West England conducted by Preston-Shoot (2017b).

Each review was read to identify if its recommendations made reference to mental health law and indicated scope for reform or review. If so, the key features of the case were identified and added to a developing Table (Table 1). Each relevant recommendation was synthesised and subject or topic categories were developed; with debate on interpretation of findings that were, for example, related to insufficiencies of training and thus might implicitly address the need for training to be mandatory or audited. We refer to each SAR by the author and year of publication, or, if the author is not given, authorship is attributed to the local Safeguarding Adults Board (SAB) that commissioned the review. We found several SARs where mental health problems and mental health services or agencies were involved but which made no recommendations specific to the law and thus these are not included.

This study draws on publicly available data and so ethical approvals were not needed. Nonetheless, we have taken care not to sensationalise the circumstances of

[2] www.surreycc.gov.uk/__data/assets/pdf_file/0017/112328/Log-of-published-National-SARs-and-SCRs-website.pdf

the cases explored. While many SARs anonymise the name of the individual concerned, in some reviews the parties' names are given and we report this because this information is already in the public domain.

Findings

Few SARs recommended direct legal reform but several made recommendations that addressed the implementation of law, variations in practice and difficulties of joint working. We include these as legal recommendations where they imply not personal lack of professional capability or competence but suggest the presence of a system wide implementation challenge that might be remedied by legislation, regulation or guidance.

First, we address direct mentions of the Mental Health Act 1983.

Mental Health Act 1983 (MHA)

Comments about MHA assessments were made in a few SARs (Sheather, 2015; Manson, 2016), and by Klée (2015) where a request for a MHA assessment of AA by his GP went no further (Klée, 2015). In Sandwell observations were made about the conduct of assessment and abiding by the MHA Code of Practice (Lake, 2017b). The MHA and policy require joint working between professionals and agencies, but problems in joint working were noted in Southwark (Kingston, 2016), Sandwell (Lake, 2017b), Teesside (Teeswide SAB, 2017), Sunderland (Corkhill, 2016), Waltham Forest (Ridley and Elwick, 2017; Budden and Elwick, 2017). Poor co-ordination, which of course overlaps with joint working, was noted in West Sussex (Boxall, 2016) and in Warrington (Warrington SAB, 2016).

The Care Programme Approach (CPA) has been used since 1990 to provide the framework that supports and co-ordinates effective mental health care for people with

severe mental health problems in secondary mental health services (Department of Health (DH), 2008). It was noted in a Southwark SAR (Harrington, 2017) that CPA practice when working with people who access services with a high degree of clinical complexity should be in line with the inclusion criteria set out in the revised CPA policy (June 2017). This SAR further recommended that other agencies be informed of local CPA policy. Elsewhere, in the case of Claire, thorough CPA documentation had been assembled by her former care provider but was not passed to the new one (Manson, 2016, p. 5). In another area, Adult AA was said to have been discharged from the CPA because the care co-ordinator and doctor making the decision did not know AA and did not consult his family (Klée, 2015, p. 4).

Two SARs made observations related to restraint under the MHA, not specifically around the restrictions authorised by Deprivation of Liberty Safeguards (DoLS) orders. In a joint SAR from Suffolk and Norfolk SABs, it was described how AA had been detained in hospital under section 2 of the MHA for assessment (Klée, 2015) and had to be moved to hospital under restraint. He was then placed in seclusion, which was questionable practice according to Klée (2015, p. 43). In another SAR the individual was awaiting a vacancy in a mental health unit (Rogers, 2018). A further SAR made observations about staff needing more understanding of Deprivation of Liberty Safeguards (DoLS) and the MCA more generally (Foster, 2018) in the context of a case where discharges from an acute hospital appeared to have been premature, uncoordinated, and poorly communicated.

Joint working concerns addressed inadequate risk assessment in a SAR from Sunderland (Corkhill, 2016). Poor or non-existent communication and a lack of risk assessment were highlighted in respect of Mr A in Southwark (Kingston, 2016), a homeless man with mental illness and physical health problems, not registered with a

GP, and for whom proposed details of any new accommodation following a hospital admission needed to be discussed with the Police for public protection reasons but were only notified to them one month later (Kingston, 2016) (see also communication concerns noted in Ridley and Elwick, 2017, Morgan, 2018; Cooper, 2016, and Kelly and Ridley, 2016). In a West Sussex SAR (Rogers, 2018) mental health records had not been shared and the care co-ordinator was reported to have failed to maintain good communications. The Approved Mental Health Professional (AMHP) service was criticised in the SAR concerning Case A because A was triaged away from an MHA assessment inappropriately by an unwarranted and inadequately supervised AMHP (Morgan, 2018).

Four SARs made substantial observations about the need for advocacy: Foster (2018), Kingston (2016), Boxall (2016), and Braye and Preston-Shoot (2017b); the latter noting that while a referral had been made for an Independent Mental Capacity Advocate one was never appointed (p. 35).

Care Act 2014

The interface of the Care Act and MHA was addressed in respect of support for family carers (Clarke, 2018 and Sullivan Smith, 2017). In the case of Adult D, whose carer was said to have their own mental health problems, there was a '*lack of professional curiosity regarding the carer/ cared for position for the couple to ensure appropriate support was being offered and any risks properly assessed*.' (Clarke, 2018, p. 15). This gave rise to the SAR's recommendation that there should be a means (unspecified whether this should be encouraging or mandated) of alerting practitioners to carer status, where relevant.

In the case of Carol (Teeswide SAB, 2017), the SAR questioned understandings of the level of threshold necessary for a safeguarding referral under the Care Act 2014

and found that agencies applied different criteria about safeguarding thresholds. Braye and Preston-Shoot (2017b) highlighted the lack of referrals to the local safeguarding service that might appropriately trigger a safeguarding enquiry (Care Act 2014, section 42) among several agencies and professionals including nursing home staff, nurses, acute hospital staff, and a psychiatrist. A SAR from Manchester (Frame, 2018) reported similar misunderstandings, by some agencies, about referrals to safeguarding services. It further observed that there was no central point of contact for those many agencies working with Adult CA, no identified lead agency and sometimes no effective or timely sharing of information (p. 9). This SAR noted that the creation of a multi-agency safeguarding hub (MASH) might help improve information sharing in such future cases (p. 8) and that IT systems were to be integrated following an organisational restructure in the NHS (p. 9). No mention is made in the SAR of Adult CA's legal status or the potential for use of legal powers and options.

More detailed critiques of the Care Act were made in respect of uncertainties about agency responsibilities covering NHS bodies and local authorities (Ridley and Elwick, 2017) in the SAR concerning 'Mark' whose care in secure hospitals was provided 'out of area'. The SAR authors pointed out that Guidance left it to local areas to make its own arrangements about responsibilities (DH, Care and Support Statutory Guidance February 2017, 14.72), but that if a person had been accommodated in several areas this could lead to multiple misunderstandings and complexities.

Mental Capacity Act 2005 (MCA)

No MCA assessment appeared to have been undertaken in the cases covered in SARs undertaken by Boxall (2016), Morgan (2018), or for Mr I of West Berkshire (Kelly and Ridley, 2016); in the latter comment was made that knowledge of policy,

procedure and guidance was poor. The SAR contained criticism of practitioners' interpretation of their common law duty of care. In another SAR, Harrington (2017) noted that mental capacity had apparently been considered in the case of Adult B, but, as it was not recorded, practice was unclear. In Barking and Dagenham SAB (2017) criticisms were made of MCA systems and practice since there were insufficient MCA assessments. Specific criticisms had earlier been made by Winter (2015), again in Barking and Dagenham, about the lack of consideration of using the MCA with Mr RC whose capacity was assumed but not assessed. Walker Hall (2018) noted inconsistent use of the MCA and DoLS; the examples given being generally when residents or patients make decisions with which professionals do not agree – for example, refusal of influenza vaccination. In this SAR the use of the MHA to compel hospital admission for assessment or treatment for David is described on two occasions (p. 14) with the SAR report commenting that the lack of a suitable hospital bed place led to major delay which placed care home staff and other residents at risk from his behaviour. During one delay the care home had been advised to call on the police for help and support. This SAR drew attention to the lack of mental health beds and acknowledged it to be a national concern, adding that this shortage applies to specialist placements for people with dementia who have challenging behaviour (p.14). It warned that these shortages are leaving 'staff and patients at an unacceptably high risk of assault' (p. 15). Likewise, a SAR from Waltham Forest (Ridley and Elwick, 2017) noted that there was simply insufficient provision suitable for people with complex behavioural mental health conditions that placed others at risk of harm and that the market lacked 'requisite variety'. The Care Act 2014's obligations for local authorities to shape the market may be relevant here in commissioning but also to fulfil their legal duties.

Self-neglect

In 15 SARs recommendations were made focusing on self-neglect. While legally these might include implications in respect of the Care Act 2014, the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (and other legislation related to public health and housing), the recommendations in the main related to the application of the MCA, particularly failure to conduct capacity assessments but also failings to record these, update them and communicate their contents. While this may suggest that this area is of general concern, in some cases of self-neglect no disquiet was expressed in the SAR about either the statutory framework or its application (e.g. Lake, 2017a).

Legal interfaces

Braye and Preston-Shoot's (2017a) pan-London review of 27 SARs observed that there had been inadequate attention to the potential use of legal powers and that this affected joint agency strategic deliberations (p. 4). They noted 'insufficient clarity about relevant legal rules' (p. 65) among some practitioners who had failed to consider powers and duties such as the use of inherent jurisdiction (ibid.). In some SARs, concerns about the application of the law applied to several pieces of legislation, in Cooper (2016) for instance, the case potentially involved the Modern Slavery Act 2015, the maintenance or displacement of the nearest relative role (under the MHA), mental capacity assessments, discharge from MHA compulsory detention in hospital, and an appeal to the Mental Health Tribunal.

In the case of Adult A (Braye and Preston-Shoot, 2017b) comments were made about systemic failings related to cross-boundary (authority) care and the lack of resources or market provision for people with highly complex needs outside hospital provision, as noted above.

Local interpretations and actions

Practice regarding other legal provision was deemed variable because of local policy differences permissible under law. In the case of Mr X, Rogers (2017) found that he had been considered vulnerable (and thus eligible for housing) in one local authority under the Housing Act 1996 but, on his move to another area, he was subsequently deemed intentionally homeless and thereby ineligible.

While possibly widespread, few SARs were so explicit about professionals' failure to seek legal advice as Braye and Preston-Shoot (2017b) when discussing a complex case of self-neglect. They observed that this could have encompassed contact with the Court of Protection to seek its authoritative views. Despite the many SARs that comment on the difficulty of balancing 'unwise' decisions with best interests, this theme is surprisingly under-developed, though Braye *et al*. (2017) have recently sought to move beyond dichotomous thinking where respect for autonomy and duty of care are in tension toward a more 'nuanced, situated and relational approach' to such cases (p. 320).

A further minority of SARs pertain to institution-wide reviews. Flynn (2016), well known as the author of the Winterbourne View Private Hospital SCR (Flynn, 2012), later undertook a SCR, that was reported as a SAR, into a care home registered to provide dementia care (which we have included here as the legal recommendations were not dementia related), Beacon Edge. She recommended that the Care Quality Commission should provide greater assurances on the 'duty of candour' placed upon care providers (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) and that the Department of Health, when revising its guidance on SARs, should consider making it incumbent on the registered provider's nominated individual to contribute to SAR processes (Flynn, 2016, p. 20).

Finally, we note the continued variation among SARs, echoing that among their predecessors, SCRs (pre-Care Act reviews with broadly the same purpose as SARs, but discretionary). One illustration of this is listed as a SAR from Devon (Usher, 2015) where the publicly available document on the SAB site is described as an 'Overview Report Executive Summary' and internally as a 'briefing paper'. Being just over 3 pages in length, this report appears to follow a SCR (although mentioning events in 2014 and the Care Act 2014) and only focused on one of a number of recommendations from a publicly undisclosed document. Nonetheless, the value of this report for our study's purposes is in noting the interface of children's educational and social care services and furthermore how the Public Health Act 1936 may have been of use in this case of neglect and squalor affecting a family. As with Flynn (2016) we found other examples of reports being called SARs but that, on further investigation, appear to be SCRs (e.g. Bournemouth and Poole SAB, 2014).

Discussion

This review found no straightforward messages for the Review of the MHA from SARs but that does not mean that they do not contain pertinent points. The first is their common finding that despite the law in contemporary adult services, across agencies, its application is variable. Continued reference is made in SARs that the MCA is not being put into practice. For any mental health law reform there would seem to be the need for close attention on how to embed changes into practice – training does not appear to be enough. This point is salient to the changes being proposed to the Mental Capacity Act 2005, being debated under the Mental Capacity (Amendment) Bill at the time of writing (end 2018). The second is that the MHA has to be considered in respect of other legislation, not only the MCA but the Care Act 2014. While not all people with mental health problems have care and support needs

before or after treatment or recovery, our analysis has revealed that many SARs make reference to complex cases, generally meaning that people had inter-related mental and physical health needs, sometimes further complicated by acute illness and movements across service or agency provision. Lastly, people with mental health problems in contemporary England are provided with care and treatment in the NHS but also by other agencies, such as commercial and not-for-profit providers of care homes, supported housing services, and in-home care or support services. While problems with understanding the law were evident among NHS professionals in several SARs, people without years of formal training, or very little, are providing the bulk of day-to-day support and are expected to have legal understandings and to practice lawfully and ethically. This expectation suggests that any new law needs to be communicated to non-professionals and their input encouraged to ensuring practice is lawful; with discussions in supervision, team meetings and audits. How to work with the complexities of effectively managing self-neglect might usefully be part of any new legal guidance.

There are limitations to this study which relate to challenges when undertaking analyses of SARs and their predecessors, SCRs. As previously noted, such reviews are variable in accessibility, format, transparency, purpose, depth and clarity (Braye and Preston-Shoot, 2017a). Indeed, some of the documentation accompanying or following a review now seems to be part of the process of review and could be usefully scrutinised to present a fuller picture of what is deemed relevant to practice or to the reading public. A local SAB's response to a SAR may be insightful and so too its pursuit of the implementation of recommendations.

However, this present study, with its focus on legal recommendations, took less of a local focus and its strength lies in the exploration of ways in which the legal system

might have been part of the explanation for failings in inter-agency work to promote safeguarding and how the law is being interpreted or (un)used in practice. Furthermore, the focus of this study provided the advantage of referring to the contemporary legislative context in England – but the disadvantage of not being able to assess whether the mental health law perspectives were identifying long-standing problems that had earlier been identified by SARs' predecessors, Serious Case Reviews. Preston-Shoot (2017a) has noted that: 'If review findings and recommendations are to fully answer the question "why", systemic analysis should appreciate the influence of national geography' (p. 53) which surely must include the legal ecology, ranging from consideration of the law to critiques over its applicability and implementation, in which SARs are constructed.

Conclusions

SARs have a local focus which renders their messages for system reform more difficult to determine than national inquiries but they have the benefit of local focus and are more numerous. There may be greater scope for SARs to ensure that the 'lessons learned' approach they adopt does include learning for law and policy communities.

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Author; SAB; Report date (date of cause)	Name / Pseudonym; Gender; Age	Notes on subject's condition	Living conditions	Incident triggering call for SAR	Lessons / findings / Recommendations	Law and guidance
Barking & Dagenham; 2017 (2016)	Lawrence Beasley; Male; 63	Paranoid schizophrenia. Diabetic.	Sheltered accommodation	Death – probably due to physical health problems	Poor systems around discharge and people with MH problems also with physical health problems. Poor communication between medical and nursing staff within hospital.	Poor MCA practice and systems. Beasley was understood to have fluctuating capacity. But there were insufficient assessments: practitioners presumed capacity and then focused on mitigation of risk caused by unwise decisions. Failings also at management level, who did not prompt use of assessments. Practice included a non-specific assessment 'around self-neglect'.
Boxall, B.; West Sussex; 2016 (2013)	Alan; Male; 41	Diagnosed with schizophrenia	Supported accommodation	Coroner: 'Alan took his own life following a prolonged period of abuse and intimidation by a known individual [John]. The statutory agencies failed through a lack of communication.' (4)	Poor co-ordination arising from silo working. No effective risk assessment for Alan or regarding John. Safeguarding alerts were not raised. No evidence of advocacy support for Alan (36-37)	No MCA assessment was made as Alan appeared not to lack capacity (29)
Braye, S. and Preston-Shoot, M.; East Sussex; 2017 (2016)	Mr A; Male; 64	Korsakoff Syndrome, arteriovenous malformation, epilepsy, encephalopathy, type 2 diabetes, and bilateral leg cellulitis and ulceration.	Nursing home	Two days before his death, the care home manager noted infestation of maggots in Mr A's ulcerated legs.	Systems for appropriate placements should be improved. There should be systems for notification and monitoring of out of county placements. Ensure there is safeguarding literacy. Improve understanding of MCA and its interface with MHA. Address advocacy shortage. (46-48)	Although capacity assessments were conducted, the SAR identifies occasions when assessments should have been conducted, and when best interests decisions were not taken, and where there was an unauthorised deprivation of liberty. (29); Failure to appoint a Paid Relevant Person's Representative. (30); Failure to resort to a MHA assessment in face of Mr A's refusal of treatment. (32); Lack of legal literacy in relation to section 42 CA; MHA and MCA
Budden, C. and Elwick, S.; Waltham	Andrew; Male; 39	Long-standing alcohol dependency;	Supported accommodation (he had	COD: alcohol related liver disease.	1. Limited mechanisms for joint working outside safeguarding, especially when ASC not	'The Care Act does recognise the dilemma posed to staff in these situations, [capacitous individuals who are making unwise choices] but unfortunately

Forest; 2017		history of self-neglect	lost his tenancy)	Responses of agencies not joined up or effective.	involved. 2. Chronic alcohol misuse not routinely seen as self-neglect. 3. Failure to see connections between alcoholism and emotional distress. 4. No widely used palliative care pathway in self-neglect who are addicted. (10-11)	does not provide further guidance.' (17)
Cheeseman, P.; Rochdale; 2017 (2016)	Tom; Male; 61	Depression; chronic alcoholism	At his home	Homicide	Evidence of good partnership working. But Tom was targeted by exploitative individuals.	No concerns about the application of law.
Clarke, A.; Lancashire; 2018 (2016)	Adult D or Amy; Female; 50	unspecified disorder of adult personality and behaviour; mixed disorders of conduct and emotions; depression; alcohol misuse. Diabetes; epilepsy	Lived with partner in private rented accommodation	COD: natural causes; pyelonephritis with ketoacidosis, with diabetes as a significant contributory factor.	Better support and practice in relation to self-neglect. Implement a carer flag on recording systems. Increase public and professional awareness of carer role.	In light of the absence of threshold criteria for s 42 CA enquiries, and the inconsistencies this can give rise to, Lancs does not have an escalation policy by which decisions may be challenged. (17)
Clifford, B.; Gloucestershire; 2017 (2016)	Hannah; Female; 26	Personality disorder. Self-harming behaviours; use of illicit drugs Morbidly obese; ongoing wound infection.	Lived alone. Received 35 hours care a week, with staff sleeping in five times a week	COD: pulmonary embolism and venous thrombosis.	Involving family and friends in support of people with MH problems. Improve accommodation options for people with MH problems. Explore innovative models of support. Improve understanding of care coordination. Monitor approach toward parity of esteem.	No particular legal concerns.
Cooper, A.; City & Hackney; 2016 (2013)	Mrs A and Mr B; Female and male; 'older'	Mrs A had dementia. Mr B experienced mental illness.	Supported housing with care scheme for older people.	Mr B allegedly sexually assaulted Mrs A; he also posed a fire risk	Mix of tenants not properly reviewed. CPA does not necessarily respond effectively to concerns. Staff unsure about handling consent and sex among older people (who have capacity). Professionals have widely variable training re fire risk and people with care and support needs. Poor ability to assess and manage risk.	No particular legal concerns.
Cooper, A;	Ms A;	Schizophrenia	Lived with	Concerns about	Calls for greater understanding of	Calls for training in: Mental Capacity

Bedford Borough and Central Bedfordshire; 2016 (2015)	female;		family members	modern slavery. There were 'serious concerns (about how Ms A) was discharged from the [mental health] ward into the hands of the people alleged to have caused her harm'. (4)	modern slavery / domestic servitude. (1)	Act, Mental Health Act, Care Act and Human Rights Act. (1)
Corkhill, R.; Sunderland; 2015 (2014)	Angela (female, 48); her brother, Barry (male, 55); and their mother, Claire (female, 78)	Angela has a long term mental illness and insulin dependent diabetes. Angela has lacked capacity in some decisions, as has Barry. All three classed as 'vulnerable'.	Lived together in 'very poor housing conditions' (13)	Angela was admitted on a MCA best interests basis to treat very high blood glucose. There may have been earlier opportunities to intervene (4)	Although Angela did not have capacity in relation to her diabetes management, Claire was left in charge of it even though she was incapable in this regard. (16-17) 'A running theme was that the issue mental capacity was used as reason *not* to take any action. The focus of the agencies involved was neither empowering, nor protecting. The authority to act was not used where it quite clearly should have been.' (17) Ensure healthcare professional representation at safeguarding meetings. (20)	Regarding MCA: there had been missed opportunities to engage it; poor use of MC terminology; poor MC practice, Inter-agency referral systems should ensure timely follow-up. (19-20)
Corkhill, R.; Sunderland; 2016 (?)	Tracy; Female; 60s	Long history of mental health problems; intermittent admissions at time of mental health crisis; diagnosis of bi-polar disorder.	Lived with husband, Jack, in own home.	Jack stabbed Tracy. She survived; he was sentenced to 7 years in prison.	Widely differing risk assessments should provoke further concern; highlight vulnerability of people with MH problems to coercive control; improve recording of inter-agency referrals; review MARAC referral process (8)	No concerns about the application of law.
Flynn, M.; Cumbria; 2016 (2013)	Beacon Edge	Specialist dementia home	Nursing home	Reports of abuse perpetrated by	Recommends that this serves as a case study for safeguarding training across agencies.	Unsatisfactory levels of engagement by the care provider in the review process.

				staff		
Foster, J.; Devon; 2016	T (Ms X); woman; 64;	Unspecified serious mental illness; and physical illness	Own home	COD: pulmonary embolism	No MCA assessment. Lack of co-ordination between agencies. Poor 'case ownership' between two organisations	Failure to conduct a MCA assessment despite references to the need to do so. (4)
Foster, J.; Gloucestershire; 2018 (2016)	Danny; Male; 64	Pre-psychotic Episodes. Borderline learning disability. Diabetic. Did not have capacity regarding his finances.	Supported living accommodation	COD: Left ventricular failure; hypersensitive heart disease and diabetes mellitus. Concerns about financial abuse.	Review hospital discharge policy. Ensure multi-agency care planning, including advocacy, in place. More support workers. Better understanding of MCA and DoLS, especially where unwise decisions lead to harm.	History of conducting MCA assessments in relation to specific decisions, including his ability to manage finances. (10) Nevertheless, continued work to embed MCA was necessary. (22)
Frame, H.; Manchester; 2018 (2016)	Adult CA; Not disclosed; 22	History of anxiety, self-harm and alcohol and substance misuse. Emotionally unstable personality disorder. Suicidal ideation	Lived with father	COD: jumped from a bridge. A note of intent was found in CA's pocket.	Issue guidance that stipulates the responsible agency for making referrals. Test the case via Adult MASH to see how it would be handled now. Waiting list management of psychological therapy referrals. Mobile phone policy to cover out of hours.	Review highlighted the danger that a safeguarding referral might not be made (here, by the police) because there was an understanding that another agency (here, health – to whom CA was being passed on) would take that decision. 'It is the view of the SAR Panel that referral should be owned and acted upon at source of information' (7)
Harrington, M.; Southwark; 2017 (2016)	Adult B; Female; 50	Recurrent depression, mixed personality disorder, and Type 1 diabetes	Own home	Prior to her death (which coincided with a fire in her flat) there had been suicide threats, poor insulin regime, and self-neglect.	Agencies failed to refer Adult B to the London Fire Brigade for a fire safety assessment. Failure to make a multi-agency plan to manage her complex physical and psychological problems. (5); Recommends an audit of section 42 decision making (around closure of enquiries) (6)	No formal documentation of MC assessments. (5)
Jasper, S.; Gloucestershire; 2016 (2015)	AT; Male; 50	Bi-polar affective disorder. Lymphoedema; morbidly obese.	Own home (Housing Association)	COD: Bi-lateral Pulmonary Emboli (blockages in the pulmonary artery) and Morbid Obesity related Lymphoedema. No question as	Review policy of DNs not making home visits (where person is not attending appointments). Should be more alert in cases of questionable executive capacity. CPA to include all relevant agencies. S 42 recommendations to be followed. Review of self-neglect policy esp. with respect to neglect of physical health	NOT A SAR – A 'PRACTICE AND LEARNING REVIEW'

				decision-making capacity.		
Kelly, K. & Ridley, A.; West Berkshire; 2016 (2015)	Mr I; male; age not given	Depression and alcoholism. Self-neglect and hoarding tendency.	At his home	COD: sudden unexpected death in alcohol and peripheral vascular disease	Poor supervision processes; poor knowledge about policy, procedure and guidance.	'There was a unanimous view amongst professionals that Mr I's capacity was retained in relation to key decisions about his health and welfare, however the reality of his daily situation suggest that he was rarely sober enough to make informed day to day choices. There was a tendency by the Local Authority and Mental Health Trust team to work with Mr I as if he lacked capacity and required 'best interest' decisions to be made on his behalf. This was probably because in relation to many day to day decisions, because he was not sober, Mr I did lack capacity. However, capacity assessments were not undertaken to confirm that and consequently there were no clear best interest care plans in place to support Mr I or the care staff working with him.' (17-18); Identifies risk-averse practice arising from practitioners' interpretation of their common law duty of care, which echoes criticism by House of Lords select committee 2014 MCA review of professionals' use of the Act. (23-24)
Kingston, P.; Southwark; 2016 (2012)	Adult A; Male; 45	Diagnosed with schizo-affective disorder; history of being detained under MHA. Insulin dependent Type 2 diabetes.	Hostel	COD: 1 a) Hyperposomalar non-ketotic coma 1 b) Diabetes Mellitis types II (insulin dependent), schizoaffective disorder 2) Natural causes to which neglect contributed	Left detention under MHA on a CTO, without being registered with a GP. 1. Proactive partnership working is vital. 2. Trust should ensure patients are GP-registered on discharge. 3. A was not treated with dignity (he was labelled as difficult), including by CC. (32-33)	'NHS Foundation Trust did not provide the Review Panel with information or assurance about Adult A's access to: 1. advocacy, in particular, an Independent Mental Health Advocate (IMHA); 2. to information that explained his rights; 3. to Adult A's involvement in his own care planning' (23) Failure to conduct a MCA assessment in relation to diabetes education reduced effectiveness of it. (24); Failure to conduct a MCA assessment in relation to hospital discharge. (26); Failure to follow MHA 'Purpose Principle' in arranging hospital discharge. (27); Poor recording by CC (31)
Klée, D.; Norfolk & Suffolk; 2015 (2014)	Mr AA; Male; 42	Paranoid schizophrenia	Rented flat. Then care home, and to PICU (under	COD: Brain damage resulting from cardiac arrest	Following discharge from CPA, there was a lack of an informed risk assessment and comprehensive plan. Raise	Use of physical control to restrain and the use of seclusion did not meet with national and local policy or in some instances with the requirements of the MHA.

			s 2 MHA)	and pneumonia	awareness and understanding among staff of self-neglect; 'lack of multi agency information sharing, comprehensive informed assessment and risk management planning is a recurring theme in this review' 48)	A well informed assessment and risk management plan that was understood and owned by all agencies could have improved the response. (48)
Lake, R.; Buckinghamshire; 2017 (2016)	Adult T; Female; young	Paranoid schizophrenia. And asthma and diabetes.	Private rented dwelling	Open verdict. Her decomposed body found in her home.	Review approach to self-neglect; s 42 CA enquiries and alternatives; thresholds for police welfare visits. Safeguarding concerns were not acted on.	Failure to raise a Safeguarding Alert or request a s 9 or s 42 CA assessment 'could well be the reason why Ms T was not effectively safeguarded.' (13) A MHA assessment should have been done on one occasion. (12)
Lake, R.; Gloucestershire; 2017 (2016)	Ted; Male; 72	History of mental ill-health; concerns about self-neglect	Sheltered housing	COD unknown, but followed serious concerns about self-neglect at a prior hospital admission	The ambulance service, the hospital and the hospital social work team should, in future, raise a formal Safeguarding Concern in circumstances of significant self-neglect (10)	No concerns about the application of the law.
Lake, R.; Sandwell; 2017 (2016)	William; Male; 82	History of being detained under sections 2 and 3 MHA	Care home	William had allegedly assaulted a fellow resident, who died. Concern centred on his treatment following this episode. He died of natural causes	1. SAB should develop a Lead Professional process. 2. Training in MCA. 3. Ensure MHA Code of Practice is followed. 4. Improvements in inter-agency working and information sharing. (12-14)	'According to the Code of Practice attached to the Mental Health Act, there should have been a multi-agency planning meeting very early on in William's stay when joint risk assessments and joint care plans could have been drawn up.' (12)
Lake, R.; Solihull; 2016 (2015)	Mr S; Male; age not given	History of suicidal ideation, and self-harm	Living with parents, following period of homelessness following relationship breakdown	Suicide, contributed to by neglect, after leaving hospital without being discharged	1. Ensure risk assessments are completed and reviewed. 2. Reinforcement of the Enhanced Observation Policy on all wards. 3. Importance of discussion of shared management plan. 4. For GPs: review of Did Not Attend policy. (14)	No concerns about the application of law.
Manson, S.; Northamptonshire; 2016	Claire; Female; 57	History of being detained under section 3 MHA;	Residential care / hospital	Neglect and omissions of care by	1. Value of investing in preventative work. 2. Favours an holistic (physical and mental	GP's and providers of community services, need to have clear escalation routes where they have concerns about service provision and be clear

(2014)		episodes of self-harm		Foundation Trust in lead up to death.	health care) approach. 3. Effective care is combination of professional knowledge and personal value base. 4. Communication is vital (services-service users and their families; within and between agencies) (67)	about when and how to refer for a Mental Health Act assessment. (7) 'It may also have been appropriate for the GP to make a direct referral to the Approved Mental Health Professionals Service (managed by Northamptonshire County Council) to request an assessment under the Mental Health Act, given Claire's mental health needs and resistance to care.' (41)
Mellor, D.; South Tyneside; 2017 (2015)	Adult D; Male; Late 50s	Manifested self-neglect; Mental and physical health problems; alcoholism	Lived alone in own home	COD: multiple organ failure as a result of severe sepsis and pneumonia	1. Enhance self-neglect and hoarding toolkit. 2. Improve risk management, ensuring engagement by all partners including GP. 3. GPs to ensure that vulnerable patients receive healthcare, and that non-attendance is followed up. (28-30)	All practitioners assumed that D had relevant capacity. There was no evidence of a MCA assessment being carried out; on one occasion access had been refused when a MCA assessment was attempted. Capacity was a concern – another time it was judged that he 'just about' had capacity; practitioners were not sure he understood the consequences of his self-neglect and turning away of care. GP was concerned D may have intimidated practitioners in this regard. (para 6.41-6.42)
Mellor, D.; South Tyneside; n.d. (2014)	Adult C; Male; 82	Schizophrenia. Given to self-neglect	At his home	COD: heart attack	Although evidence of joint working at times, his self-neglect was seen primarily as 'somebody else's business' (p36)	'The case strongly suggests that practitioners across a number of agencies did not use the Mental Capacity Act well. Often Mental Capacity assessments went unrecorded. On occasions the outcomes of Mental Capacity assessments were not communicated to agencies which needed to carry out prompt Best Interests assessments. In some cases practitioners appeared to lack confidence in their use of the Act.' (para 7.5)
Morgan, P; Bedford Borough and Central Bedfordshire; 2018 (2016)	Case A; female; 35	Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Anorexia/Bulimia; Borderline Personality Disorder. High Functioning Autism Spectrum Disorder	Residential home	Death in a traffic accident. Concern raised over risk assessment in relation to her move to a residential unit; information shared with staff; actions of the AMHP service	Despite risky behaviour, there was insufficient strategic oversight of her care. Referral for MHA assessment was inappropriately screened out by a non-warranted AMHP. (4)	'Despite professional concerns and having been assessed as meeting the first stage of the two stage functional test for capacity, at no point except at her point of admission, was a formal Mental Capacity Assessment undertaken despite increasing evidence that would suggest that she might lack capacity in some areas of decision-making; equally, at no stage of her placement was consideration given to action under the Mental Capacity Act 2005, all attention was focused on action under the Mental Health Act 1983.' (4)

Plymouth; 2017 (2012)	Ruth Mitchell; Female; 40	Diagnosed with schizophrenia	Own home	COD: bronchopneumonia and pulmonary embolism	1. Agencies must develop information sharing processes. 2. Where return to CPA may lead to disengagement and there is concern about self-neglect, then a Safeguarding meeting should be considered. 3. Agencies must follow self-neglect and hoarding policy. (41-42)	Review suggests there were times when MCA assessments should have been undertaken, and that insufficient attention was paid to her executive capacity (30; 44)
Preston-Shoot, M.; Havering; 2017 (2015)	Ms A; Female; 20	Complex mental health needs, some arising from Disorganised Attachment Behaviour	Own flat.	COD: jumping from window of her flat, while drunk – unclear whether she intended to commit suicide	Management of complex cases with vulnerable young adults; training provision, supervision and staff support; record keeping and information sharing; specialist support; review of eligibility criteria and thresholds	Recommends a review of thresholds for ss 9 and 42 assessments (since safeguarding had triaged the case but did not do any assessments). (16; 34) Recommends review of mental capacity training (learning event had concluded that capacity had been too easily presumed). (21-22)
Rees, K.; Hampshire; 2017 (2016)	Mr. C; Male; 66	History of psychotic depression. Mild learning disability, epilepsy.	Supported housing, then nursing care home	COD: sepsis, pneumonia and urinary tract infection and severe malnutrition. Self-neglect	Better transition planning. Communication and coordination. Agree who will be the key worker. Focus on IMCA role. Involvement of family important.	MCA is legal framework even where BI decisions are not leading to solutions – there was a missed opportunity to hold a best interests meeting. (13)
Ridley, A. and Elwick, S.; Waltham Forest; 2017	Mark; Male; 30	Primary diagnosis of personality disorder and ADHD. History of detentions under the MHA, including for violent threats toward his mother. Earlier thought to have a learning disability.	Series of hospitals	Mark sexually assaulted fellow patients. Case raised issues of risk management, commissioning practice and safeguarding.	1. The Transforming Care Agenda set targets for bringing people with LD closer to home. Inadequate local provision meant that Mark was placed somewhere that could not support him safely. (17) 2. Poor co-ordination between social care led safeguarding enquiries and health led quality concerns. (21)	No concerns about the application of law.
Rogers, L.; West Sussex; 2018 (2016)	Adult F; Male; 23	Diagnosed with Schizoaffective Disorder and Asperger's syndrome	Lived with his parents, his main carers.	He absconded from Clinical Decision Unit, while waiting for a psychiatric bed. Fell from hospital roof; possible	Poor continuity of care across settings. Care Plan limited in scope and aspiration. CC failed to maintain good communications. Leave poorly managed. MH records not shared. Lack of MH bed (59-60)	No concerns about the application of law.

				suicide.		
Rogers, L; Brighton & Hove; 2017 (2014)	X; Transgender; 59	Diagnosed with a personality disorder and learning difficulty. Long history of serious self-harm	Rough sleeping, made himself intentionally homeless, and moving area	Death through 'misadventure to which self-neglect contributed' Coroner	Because of his vulnerability and the threat he posed to others and because he was out of area, it was a difficult case. But multi-agency safeguarding procedures were not invoked.	Under s 189 Housing Act 1996, X was classed as vulnerable (because of his mental illness), but when he moved area, to Brighton, the Housing department, after temporarily housing him, gave him notice to quit on grounds he was intentionally homeless.
Sheather, M.; Hampshire; 2015 (2014)	Ms B; Female; 46	Mild learning disability, personality disorder and epilepsy	Residential home	COD: heart failure and obesity and depression	Three main themes: 1. Impact of her underlying mental health needs; 2. Communication with her after discharge from hospital; 3. Failures in relation to assessment, information sharing and decision making.	Failure to understand MCA principles: e.g. tendency to make general capacity statements (as opposed to ones relating to specific decisions). There should have been a capacity assessment regarding moving to another care home and in relation to her approach to her own care. (14-16) Her voice was not sufficiently heard in the MHA Assessment. (16)
Sullivan Smith, E.; Buckinghamshire; 2017 (2016)	Adult Q; male; 74	Bipolar Affective Disorder. And Ankylosing Spondylitis and Parkinson's Disease.	Private rented dwelling	COD: bronchopneumonia etc.	Review approach to self-neglect; assessments under the CA; referral for MHA assessment; MCA assessments; information sharing; s 42 methods (£ abuse)	Actions of carers for Q may have masked the level of his self-neglect from LA. A more holistic approach by LA, including s 10 CA carer assessments would have been preventative and protective regarding Q's self-neglect. (14) The s 42 CA enquiry failed to bring with it a holistic approach to Q's care – especially important given it led to his main carer withdrawing her care (Q accused her of £ abuse). (28) There should be better information provision on alternatives to MHA detention. (15) MCA assessments were too few and too brief. (16-17)
Teeswide; 2017 (2014)	Carol; female; 39	Personality disorder and alcoholism	At her home	Two teenage girls were convicted for her murder.	Poor care pathway for people with dual diagnosis. Risk assessments made by integrated MHT were limited because they were not multi-agency. (40); Safeguarding thresholds and criteria were inconsistently applied by agencies. (40); 'A multi-agency mechanism to determine her risk and possibly identify the young people [who were harassing her] was simply not there.' (41); Failure to join up safeguarding	There was a failure to record capacity assessments. Though they were reported as having taken place, they may have lacked the requisite formality. (37) This was a complex case for professionals to handle because she had personality disorder, and because undue influence and coercion were in play. (37-38)

					and community safety services. (43)	
Teodorini, A.; Kent and Medway; 2017 (2016)	Mrs D Female; 68	Recurrent depressive disorder and emotionally unstable personality disorder (borderline type).	Independent living accommodation	Died following setting fire to her own clothing	Train staff to recognise self-neglect; to make MCA assessments. Improve co-ordination of agencies. Joint review of health and social care needs annually.	The unanimous view of professionals that she had capacity in relation to health and welfare decisions was not backed up by MC assessments. Failure to work consistently within MCA principles. Absence of documented capacity assessments. (10)
Walker Hall, N.; Lancashire; 2018 (2015)	John; Male; 86. David; Male; 76	Vascular dementia	Care home	David assaulted John. John's injuries contributed to his subsequent death	Incomplete information is impacting on the quality of preadmission (to care home) assessments;	Inconsistent use of the Mental Capacity Act and DOLS when patients with dementia refuse prescribed or advised treatments and interventions.
Ward, S.; Cumbria; 2015 (2013)	Adult Y; female; 84	Alzheimer's and Crohn's diagnoses	Care home	COD: perforated bowel. There had been a number of falls, concerns around her steady weight loss and conflicting practice around the administration of her various medication (2)	Discharge planning process should be carefully co-ordinated with Adult Social Care. Recording and acting on evidence of falls and weight loss should be improved.	Although there was a general consensus that Y had lacked capacity and a best interest decision was taken, no mental capacity assessment was conducted. (4)
Warrington; 2016 (2015)	Adult A; Female; 23	Referred to mental health services because of low mood and anxiety.	Unclear	Discretionary SAR, following Adult A's suicide. She had five children and had been in a 'high risk domestic abuse relationship' (2)	Thresholds meant that having children taken into care did not entitle person to have an allocated worker. Time constraint on workers left them with incomplete picture of A's situation. Current protocols meant that information could not be shared and agencies' approaches were not co-ordinated. (3-4)	When work with a person fell outside MCA, MHA and adult safeguarding then professionals felt unable to share information. This led to a lack of co-ordination between agencies and highlights the importance of having a lead professional who engages with the person. (4)
Winter, I;	RC; male;	Bi-polar disorder	Supported	Death – due to	Approach to dysphagia.	Review use of MCA; 'It is of particular note that the

Barking & Dagenham; 2015 (2015)	61	(he had a moderate learning disability)	accommodation	choking on food		Mental Capacity Act (MCA) was never fully considered for RC. The MCA could have provided a standardised and comprehensive framework in which RC's needs could have been understood, recognised and then worked with by all. Too often there were assumptions about his capacity (or lack of it) but this was never properly assessed.' Para 10.5

Abbreviations used in the table

ASC: adult social care
CA: Care Act 2014
CC: Care Co-ordinator
COD: Cause of Death
CPA: Care Programme Approach
MCA: Mental Capacity Act 2005
MHA: Mental Health Act 1983
SAB: Safeguarding Adults Board