Identifying and responding to closed cultures

Guidance for CQC staff

Contents

1. Introduction

The abuse at Whorlton Hall, Winterbourne View, Mid Staffordshire Hospital and other services highlighted the abuse and other breaches of human rights that result from closed cultures and the impact that these had on people.

Amanda's story below illustrates what it is like to feel powerless within a closed culture in a mental health setting. However, her story could take place in any health or social care setting where there is a closed culture, and people feel either too scared to voice their concerns or unable to make their voice heard.

Amanda's story

When I was a patient in a closed culture on a psychiatric ward, I felt completely vulnerable. The staff had all the power and I felt that whatever I did or said I was completely powerless. Some of the senior staff were so arrogant that they controlled everything. I could tell that some of the more junior staff disagreed with what was happening, but even they didn't feel able to speak up for the patients' rights (and presumably for their own working environment too). Even when I did try to say that things weren't safe, I was ignored. It felt like all my experiences, past education, training and work counted for nothing because I was the one who was mentally ill and they were the 'professionals'. I may have been unwell, but I still knew that what was happening was wrong and was rejected when I tried to articulate this to the 'powers' in the organisation.

This happened to me as someone who is articulate and confident to speak up. We now need to stand up for those people who are in similar situations but are unable to make their voices heard.

During the COVID-19 pandemic, there is an increased likelihood that inherent risk factors and warning signs will be present in more services. This is because more services are effectively operating as closed environments with a reduction in external oversight and with potential staffing and leadership challenges. As a result, we must identify where closed environments might develop into closed cultures.

Purpose of this guidance

This guidance and its associated training will support operational staff to:

- understand what a closed culture is
- identify a closed culture
- understand what potential breaches of our fundamental standards involving human rights look like
- be alert to signs of breaches of our fundamental standards in services with a closed culture
- know the right questions to ask at the right time
- ensure the voices of people who use services are sought, listened to and acted on
- determine next steps if evidence is uncovered that suggests people are at risk of harm or have experienced harm or abuse.

2. What are the risk factors of developing a closed culture?

By a closed culture we mean **a poor culture that can lead to harm, which can include human rights breaches such as abuse.** Any service that delivers care can have a closed culture, and features of a closed culture include:

- staff and/or management no longer seeing people using the service as people
- very few people being able to speak up for themselves. This could be because of a lack of communication skills, a lack of support to speak up, or fear of abuse.
- this may mean that people who use the service are more likely to be at risk of harm
- this harm can be deliberate or unintentional. It can include abuse, human rights breaches or clinical harm.

From our experience of regulating services, the likelihood that a service might develop a closed culture is higher if **one or more of the four inherent risk factors** described in the table below is present. Section 3 gives guidance on the warning signs that a closed culture may present.

Table 1 - Inherent risk factors

Inherent risk factor	Signs that risks may be higher in a particular service
People may be experiencing poor care	• People are highly dependent on staff for their basic needs. • People are less able to speak up for themselves without good support from the service, for example, in learning disability or children's services or care homes for people with dementia. • Restrictive practices are used. • In healthcare, people stay in a service for months or years.
Weak leadership and management	• There are regular changes in management or managers are not regularly present and at times the service may run without a manager. This may be more likely during COVID-19 due to staff being off sick or self-isolating. • Managers are frequently absent from the service if they are responsible for two or more sites/ teams – as a result, they are rarely present to challenge poor practice or promote good practice. • The workforce comprises many members of staff who are either related or friends, causing 'cliques' to form.

Inherent risk factor	Signs that risks may be higher in a particular service
	• There is a lack of openness and transparency between managers, staff, people using the service and external professionals and organisations. • Managers do not lead by example. • Staff are not supported or encouraged to raise concerns. • Managers fail to monitor, and address issues raised by staff, people using the service, relatives and visitors to the service. • Managers fail to respond to recommendations of others, for example professionals, commissioners and regulators. • There are differing views between the multidisciplinary team or managers and care staff about how people are being supported.
Poor skills, experience and training of staff providing care	• There is a high turnover of staff. • There are consistent staff shortages. • There is a high use of agency staff who do not know the people they are caring for (in mental health hospitals or residential care). • There is a lack of suitable induction, training, monitoring and supervision of staff. • During COVID-19, employment checks are not as thorough (giving job applicants who could harm people who use services greater opportunities to be employed). • Shift patterns within the service mean that the same people are always working together, and staff are not mixing with other colleagues. • Staff work excessively long hours or overtime.
Lack of external oversight	• The service is in an isolated location resulting in people using the service having limited access to community services and facilities and less opportunities for friends and family to visit. • There is a lack of monitoring by outside agencies. • There is limited interaction with outside agencies due to failings on the part of the service to

Inherent risk factor	Signs that risks may be higher in a particular service
	submit mandatory information such as notifications or safeguarding referrals. • There are few visitors. • During COVID-19 there are restrictions on access to, and less external oversight of **all services** by family, friends, social workers, visiting health care professionals, commissioners and CQC.

3. What are the warning signs of a closed culture?

We always need to monitor services with inherent risks of a closed culture more closely than those without. However, we need to be alert to warning signs of a closed culture in all services.

Unlike the inherent risk factors that indicate that a closed culture is more likely, warning signs suggest that a closed culture is developing or has already developed in a service. Warning signs can also be present in services with a low inherent risk of a closed culture, as a closed culture can develop in any service.

Where we see these signs, it is highly likely that there are breaches of the fundamental standards and potentially human rights breaches. As a result, we need to look at what action we can take to protect people using services from harm.

Table 2 - Warning signs

Warning signs	What to look out for
Poor experiences of care	• Information of concern about care being received through 'Give feedback on care' or other sources (see section 5). • Staff not understanding nor speaking warmly about the people they are caring for. • Care plans not being individualised or reflecting the person's voice. • Lack of reasonable adjustments for disabled people, as described in the Equality law section below • Poor or absent communication plans for people who have communication needs, such as people with a learning disability, autistic people, people with dementia or any specific communication needs. Communication plans not being followed. • Potentially punitive approach to care. • Decisions imposed on people without legal authority/legitimate aim. • Reports of or observations of people who use services seeming uncomfortable around staff and not able to communicate openly.
Use of restrictions and restraint (including restraint, segregation and seclusion)	• General blanket restrictions in place that are not the least restrictive option and/or are not in place for a legitimate reason. Restrictions have been imposed without an assessment of individual needs. • Restrictions are in place that may have been imposed for legitimate reasons, but are not

Warning signs	What to look out for
	subject to review. There is also no evidence of them easing or relaxing over time. • During the coronavirus (COVID-19) pandemic, blanket restrictions are in place, leading to people being unnecessarily restricted in being able to go out for exercise or see visitors (especially in learning disability, autism and child and adolescent mental health services where government advice is that people should be able to do this). • Implementing isolation or social distancing, for the purpose of managing COVID-19, by using restraint that may not be appropriate/least restrictive, for example shutting doors, blocking exits with objects, or physically restraining people, to ensure social distancing. • Use of physical restraint. • Use of long-term segregation in hospitals or people being locked into their flats or stopped from coming out of their rooms in adult social care services. • Frequent or prolonged use of seclusion. People being asked to go to their rooms or another area in care homes and prevented from leaving. • Poor application or understanding of the Mental Capacity Act (MCA) and Mental Health Act (MHA), including not following the MCA and MHA Codes of Practice.
Physical environment	• Adaptations to manage COVID-19 are having a negative impact on people using the service. • There are concerns about the condition and suitability of the physical environment that people are living in. In mental health hospitals, these are not meeting the MHA Code of Practice. • The way premises are being used leads to increased restriction or lack of choice for people. For example, in mental health services, seclusion facilities are being used for long-term segregation without any adaptions to meet the needs of the person.
Poor skills, experience and training of staff providing care	• Staff are not being given training that enables them to meet the needs of people using the service. For example, a lack of specialist

Warning signs	What to look out for
	training in autism or the care or people with a learning disability or dementia. • High staff turnover, even if there is a small core of longstanding staff. • Information from concerns that suggest that some staff are contributing to a punitive culture. This may include, for example, taunting people using the service or using restrictive practice as a punishment. • Staff reporting bullying or whistleblowing. • Staff being discouraged or afraid to 'speak out'. This may be due to ineffective whistleblowing policies, or a lack of support and guidance for staff. There may also be a lack of challenge to poor practice as staff are accepting ‘how things are done’.
Poor and weak management and leadership	• A failure to provide regular, good quality staff supervision and time for debriefs and reflective practice. • Poor response to complaints or allegations, for example from families or people that use services. Services dismissing concerns from people who use services or their families or advocates and not actively addressing them. • Failure to ensure people are safeguarded against discrimination, harm and abuse. For example, specific concerns raised in relation to this or a high or increasing number of safeguarding incidents, complaints or other notifications. • Allegations of staff bullying other staff and managers response to this (there is often a link between staff bullying and poor care treatment). • Information from concerns or whistleblowing that leaders are “covering up” issues of concern or falsifying records.
Lack of external oversight	• Families do not have a good working relationship with the provider or are not aware of how their loved one is being cared for. • During COVID-19, the service does not facilitate face-to-face visits where possible in line with guidance and has failed to promote technology or use low technology solutions, like

Warning signs	What to look out for
	phone calls, to facilitate remote access with family and friends. • The service does not respond to CQC, commissioners or other external requests for information in a timely way. • Few or no notifications of safeguarding or other incidents.

4. What is the potential impact of closed cultures on human rights and equality?

A parent's story

"My daughter was held down by nurses on an inpatient unit. I think it happened as she gets frightened around strangers, as people with autism often do. She felt incredibly frightened and tortured.

Since then she has had a full sensory assessment, it shows she has sensitivities to smell, taste, touch, noise and bright lights. Services should understand human rights."

People using services that have closed cultures, are more likely to be exposed to risks of abuse, avoidable harm and breaches of their rights under the Human Rights Act 1998 and the Equality Act 2010.

Our regulatory role is grounded in our fundamental standards, which are informed by human rights principles. Breaches of the fundamental standards inform our decision as to whether we act.

Good care is underpinned by an understanding of and a respect for people's human rights. As a result, it is essential to understand how importantly a service views human rights. As a public sector body and a member of the UK National Preventive Mechanism we have a duty to act when we believe that someone's human rights are not being protected.

Where there are warning signs that abuse, harmful behaviour or human rights breaches may be likely or are taking place, we need to take these into account when we assess whether there are breaches of the fundamental standards.

The table below describes the key human rights articles and types of scenarios where they may be raised.

Table 3 - Human rights articles and scenarios

Human rights article	Scenario where the human rights article might be raised
Article 2: Right to Life	• If the standard of care planning or delivery places a person using a service in a potentially life-threatening situation, this raises a potential breach of Article 2. • This includes decisions and actions taken in the service where a person resides. For example, where staff fail to investigate potentially life-threatening healthcare conditions. For people with a learning disability or dementia, this could be where they fail to identify symptoms of such a condition because they do not pick up the behavioural cues from the person. • It also includes partnership working with other services. For example, during COVID-19, some services have incorporated blanket DNACPR (do not resuscitate) decisions into end of life care plans,

Human rights article	Scenario where the human rights article might be raised
	without the correct decision making processes for individual people.
Article 3: Right to freedom from torture, inhuman or degrading treatment	• If the standard of care planning or delivery places a person using a service in a situation where they are experiencing ongoing and serious suffering amounting to inhuman or degrading treatment, this raises a potential breach of Article 3. • This relates to all aspects of a person's treatment and or care planning and delivery and involves the need for robust safeguards to be in place. It includes failing to meet people's basic needs, such providing adequate toilet facilities or drinks. • It also potentially relates to the provision of support to people who receive care from external agencies. For example the failure to make clear to external professionals the communication needs of a person if this results in serious suffering. • It also includes failing to allow people to have regular access to fresh air, or to a member of staff so someone can ask to go outside or to a toilet.
Article 5: Right to liberty and security	• If decisions taken in respect of a person's care result in disproportionate and unnecessary infringements on their liberty, this raises a potential breach of Article 5. • A persons' right to liberty must be taken into account where seclusion, long-term segregation and restraint is considered or used and where people are unable to leave a service of their own free will. Such actions must be undertaken correctly within legal frameworks, for example the Mental Capacity Act 2005 and the Mental Health Act 1983. This includes ensuring there will be appropriate safeguards and reviews in place.
Article 8: Right to respect for private and family life	• If decisions taken in respect of a person's care results in disproportionate and unnecessary infringements on their privacy, dignity and enjoyment of a family life, this raises a potential breach of Article 8. • The planning and delivery of health and social care must comply with people's right to receive dignified and respectful care. Their right to have access to family and to be afforded privacy must be central to care planning and delivery.

Human rights article	Scenario where the human rights article might be raised
	• There are many examples, including failings by a service to support people to have regular contact with their family and friends during covid-19, the inappropriate use of CCTV and the use of degrading language by staff in front of people.

Equality law

Under the Equality Act 2010, people using services have the right not to be discriminated against on the basis of protected characteristics, such as their gender, ethnicity, disability, religion or belief, sexual orientation, or gender identity – or even perceived protected characteristic, such as perceived sexual orientation.

Disabled people also have a right to 'reasonable adjustments' to ensure that they do not experience a lesser standard of care simply on the basis of their disability. Reasonable adjustments to help people to communicate, as outlined in the Accessible Information Standard, are also a legal requirement under the Equality Act 2010. Reasonable adjustments may be less likely to be made in closed cultures that are responding to people's individual needs in relation to their environment. For example, the sensory needs of autistic people or the needs of people with mobility or cognitive impairments to maximise their independence through having easy access to mobility aids or dementia-friendly environments.

It is important that we also identify if there are circumstances where people's human rights or rights under the Equality Act are at risk of or are already being potentially breached in **any** health and care setting in both services with closed cultures and those without. For example, if there is bullying or taunting by staff towards people using services, this may be based on a protected characteristic such as their disability or ethnicity.

5. How can we identify a closed culture?

"I tried to say what I needed but they wanted me to do something else, but I needed someone to talk to me not music, no-one listened, other things were in my care plan and they picked what I needed not me I was scared and couldn't explain."

"CQC need to speak to the people that know the most about the care being provided, not just the next of kin who is on the paperwork held by a hospital or home. My friends visited me much more than my family, but they weren't considered."

"Families are often 'cut out' of conversations about their family members care, this also extends to a general defensiveness from services on any questioning. A defensive culture prevents a learning culture so should be something CQC look for."

It can be hard to identify a closed culture and uncover abuse, including human rights breaches – particularly when there is an element of deception or covering-up by either the management, senior staff or a group of staff. However, as the regulator it is our responsibility to try to do this both through our monitoring of services and inspecting.

To identify warning signs, we must know what to look out for and ask the right questions while making sure that we hear and listen to the voice of people who use services and their families.

During COVID-19, as all services have become more closed environments it is increasingly important to ensure that we continue to hear people's voices and act on any information that is of concern.

There are many ways that we can listen to people's voice, both while on site or by remote methods. However, to make sure that we can make the most reliable judgement of how a service is providing care, in all services we must:

- **make sure we gather people's voices through different ways** (see table below).
- take notice and **give appropriate weight to people's voice** in the evidence we gather to inform risk, in the actions that we take and within our reporting.
- think about what the **person may be telling you either directly or indirectly** – could it be signs of a closed culture or abuse, including human rights breaches?
- **Always speak to people that use the service**, this could include people that have recently been discharged or moved.

The table below outlines sources of information to review, including speaking to people that use services, to make sure that we hear their voices.

Table 4 - Sources of information

Source of information	Description
Speak to people that use services	It is vital that we ensure that the views and experiences of people who use services are used to drive other regulatory activity, such as whether a

Source of information	Description
	responsive inspection is needed and what any inspection should focus on. Always think of the best way to do this – for example during COVID-19 can this be done remotely through video link from a phone or tablet? Consider if an Expert by Experience or advocate could support with this. Always consider the communication needs of those people you are liaising with to be able to ensure you can establish their views for example through translators, British sign language, talking mats, Makaton or Picture exchange system (PECS). For learning disability services, it is essential that any communication is sent to the service in easy read, including inspection reports.
Speak with family and friends of people who use the service	As part of the monitoring of the service, CQC can request a list of relatives or friends of people using the service. A letter could be sent by email asking for their consent to a call and to specify the best way to contact them (video call or phone) and reminding them of how to raise a concern and the 'Give feedback on care' form. If unable to contact relatives or friends via email, to discuss with the manager of the service or advocate the best way to contact them. **This should always be considered if there are concerns about a closed culture.** Where appropriate consider an expert by experience having these conversations with families.
Enquiries – including safeguarding, whistleblowing, incidents and deaths	Enquiry information coming through our National Customer Services Centre (NCSC) will now include monitoring information about vulnerable groups and protected characteristics. This includes learning disability, autism, physical impairment, sensory impairment and/or long-term condition. Other equality information, such as ethnicity and sexual orientation may also be important to pick up any potential discrimination on these grounds.
Qualitative briefings	These give findings from a thematic analysis of information from enquiries and other sources of information such as whistleblowing complaints and feedback on care. These appear in the Emergency Support Framework (ESF) alongside the risk model.

Source of information	Description
	Currently briefings are created for services where there is identified as being at medium risk overall with a larger volume of whistleblowing or concerns raised - in independent hospitals (including learning disability and autism services) and residential and community adult social care services.
Give feedback on care	Information from 'Give feedback on care' is gathered by NCSC and intelligence who input this information into CRM for inspectors. These are triaged and fed back to inspectors via CRM. This information is used to inform risk through the ESF assessment stage.
Complaints and concerns	During COVID-19, Mental Health Act (MHA) reviewers are responding to complaints regarding people currently detained under the Mental Health Act. MHA reviewers are contacting patients regarding their complaint and will then contact the provider to discuss the concerns and try to find a resolution. This information is shared with the inspector. Concerns received for other services are passed to local inspectors for information.

The table below outlines the additional information that can be gathered to hear peoples voices through regular monitoring activity or before an inspection.

Table 5 - Additional sources of information

Additional source of information	Description
Additional information	Following whistleblowing, safeguarding or notifications (including Deprivation of Liberty Safeguard (DoLS) notifications) ask for information from the service to inform understanding about how care is being delivered. Request incident forms, care plans and other relevant information to be sent to us and reviewed.
Speaking to staff, advocates and visiting agencies	This can be done off site during monitoring or during inspection activity during COVID-19. Inspectors can ask the manager of the service for email or contact details of staff, advocates or visiting agencies so the inspector to can arrange to get direct feedback from these people. Inspectors can then email, phone or video call staff, advocates and visiting professionals to interview them.

Additional source of information	Description
	They can also provide details of our ‘Give feedback on care’ form that can be completed anonymously. Mental Health Act Reviewers are in regular contact with Independent Mental Health advocates as part of their methodology during COVID-19.
External agencies	By agencies we mean local authorities, clinical care groups, Healthwatch, commissioners and NHS England. Inspectors and inspection managers can engage with these local stakeholders before an inspection or as part of relationship management to gain information about the service and the experience of people receiving care.

6. What action should we take where there are concerns?

The following methods can be used when we identify concerns about a closed culture. These can be used during monitoring, inspection activity or when taking other actions.

Reviewing risk

When reviewing risk, it is important that all information is considered and appropriate weight is given to what people are telling us about their experience of care. Services that were previously rated as good or outstanding could be struggling during the pandemic and require our attention.

If using the Emergency Support Framework (ESF) and we are concerned that there are warning signs of a closed culture where people are at risk of harm or abuse, **we need to follow the decision to assess process**. This might result in increased monitoring, virtual inspection activity or an on-site inspection. The decision to assess tool includes both inherent risk and warning signs of a closed culture, described at a high level.

The following methods can be used at any time to support decisions about steps to take when we identify concerns about a closed culture.

- **A conversation with the provider or registered manager.** This could be carried out initially within the framework of ESF. However, where the concerns are more serious these need to be followed up either before or after the ESF call through the decision to assess process.
- **Conversations with people using the services and relatives**. It is essential to gather feedback and follow up on enquiries or other information by speaking to people and relatives as much as possible. An Expert by Experience should be involved where possible.
- **Review of care plans and incidents.** In adult social care, inpatient mental health services and children's services review of care plans and incidents should be used to assess whether their care and treatment is person-centred and meeting their needs.

Reviewing individuals' care

Reviewing individuals' care is key to understanding how the culture of the service affects people using the service. It should include looking at care plans and, if applicable, positive behaviour support plans.

Care plans can be looked at remotely following an enquiry, while preparing for an inspection or while on site during a site visit. They can also be emailed to CQC by the provider through secure email so that inspectors or Mental Health Act reviewers can review them in response to specific enquiries or look at them remotely as part of inspection activity.

In learning disability and autism services, mental health services and those for people with dementia, care plans and positive behaviour support plans should clearly

show how the person is being supported, what may trigger any behaviour which may be challenging for staff and how staff should support people with this.

Prioritising care reviews

It is important to prioritise reviewing the care of people who might be more vulnerable to human rights breaches. This includes:

- people that the service identifies as showing distressed behaviour, which can be challenging for the service
- anyone currently in long-term segregation and/or deprived of their liberty through, for example, a Deprivation of Liberty Safeguard, or detained through Mental Health Act
- people a long way from home or without regular visitors
- people who have been abused in other settings or have 'allegation risk assessments' in place
- people who face significant barriers in giving feedback themselves, for example people who are non-verbal.
  (***Note:*** *In some services, this might be most people using the service. In this case inspectors should use their judgement about who might be most vulnerable to human rights breaches.*)

Reviewing individuals' care

Consider the following when reviewing individuals' care:

- Do the care plans give a good picture of the person, what their care and treatment is and how they are being supported?
- Do the care plans describe people and their needs in a respectful way?
- Are there reasonable adjustments in place for individual disabled people? For example, in relation to communication, sensory overload and reducing distress.
- Does the service meet the Accessible Information Standard?
- If the needs of people with distressed behaviours are not met, there is a higher risk of a culture reliant on excessive restraint developing (this could be physical, chemical, mechanical, seclusion or segregation.) Are triggers for distressed behaviour clearly documented and are techniques for preventing behaviours from escalating documented?
- The National Autistic Taskforce has produced an independent guide to the quality of care for autistic people, which highlights many relevant issues for autistic people.

Reviewing an individuals' care should include speaking to or communicating with the person if possible and to their relatives or friends, advocates and local authority or commissioners either before, during or after the inspection visit.

Carrying out focused, targeted or virtual inspections

We should not approach inspecting services with a high inherent risk of a closed culture by 'looking for good' without looking at the full picture. We should look at all the evidence to assess the truth of people's experience in using the service.

We do this by:

- **always carrying out unannounced inspections**.
- **always using an Expert by Experience**
- **carrying out evening and weekend inspections**, where this may give us useful information about the culture in the service, either as a follow-up day or as the first day of the inspection.
- **gathering as much information as possible** both on and off site about a person's experiences care and what it means to them.
- making sure that we have **enough time to speak informally with people** using the service. This might mean that more time is needed for the inspection.
- where possible and appropriate, make sure that people are spoken to on their own, without the shadow of their carer, care worker or the doctor standing over them.

It is important to speak to as many people as possible, such as specific members of staff and other professionals who visit the service such as advocates. If they are not present on the day, this can be arranged after the unannounced day or to take place by phone or video call after the visit.

In mental health services, MHA review visits are also a valuable way of gathering general observations and more informal feedback from staff as well as people using the service.

Speaking with people with additional needs

When speaking with people who use the service, think about how to best communicate with them. For example:

- in **learning disability services** make sure that there are inspectors, specialist advisors (SPAs) or Experts by Experience who have knowledge about and can communicate by using talking mats, Makaton or Picture Exchange System (PECS).
- in **older people's services** make sure that there are inspectors, SPAs or Experts by Experience with knowledge and experience of communicating with those who have dementia.
- in **adult social care** the short observational framework for inspection (SOFI) is used in most settings. It is also used in some settings in hospitals. It is most effective for services when we wish to review the way in which staff in services interact with people using relevant services. For smaller groups of people (two to three people) it may be better to use other observation methods.
- in **mental health services** consider using SOFI where appropriate.

Using enforcement action

When considering enforcement action, follow the enforcement policy and apply the decision tree and then apply the COVID-19 emergency framework. This guidance document should be referred to when deciding on the most appropriate enforcement action.

We should consider whether there is a breach of the fundamental standards. Although we cannot enforce against a human rights breach itself, we should consider whether a potential human rights breach amounts to a breach of the fundamental standards. This includes considering enforcement action under Regulation 12(1) – Safe Care and Treatment or Regulation 13(1) and (4) Safeguarding Service Users from Abuse or Improper treatment.

For civil cases, the enforcement decision tree includes decisions about whether any breaches amount to:

- significant infringement of any person's rights or welfare
- a reduction in quality of life

We consider criminal prosecution in cases where there is avoidable harm of a physical or psychological nature or a significant risk of such harm occurring. We also consider criminal prosecution where false information has been supplied wilfully; information or explanations have been withheld; or there has been an intent to deceive, in relation to a matter that gives rise to significant risk. More information is available in our Enforcement policy and Enforcement decision tree.