INQUEST submission to CQC consultation:

Health and social care in prisons and young offender institutions, and health care in immigration removal centres

24.05.15
INQUEST’s expertise

1. INQUEST is the only independent charitable organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths, their investigation and the inquest process to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. We have a proven track record in delivering an award winning, free, in-depth complex casework service on deaths in state detention (prison custody, police custody or following police contact, immigration removal centres (IRC) and psychiatric detention) or involving state agents. We work on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability.

2. Our specialist casework service gives INQUEST a unique perspective on how the whole system operates through our monitoring of the investigative and inquest process. We work with bereaved families from the outset, facilitate their legal representation and work alongside them until the conclusion of the investigation, inquest and other legal proceedings. It enables us to identify systemic and policy issues arising from avoidable deaths and the way they are investigated, and to ensure this is fed through to government, policymakers and parliamentarians. Our evidence to this CQC consultation draws on this expertise.

3. INQUEST participates in the Ministerial Council on Deaths in Custody through representation on the first tier, the Ministerial Board on Deaths in Custody. INQUEST’s co-director Deborah Coles is also a founding member of the cross government sponsored Independent Advisory Panel on Deaths in Custody, the second tier of the Ministerial Council.

4. Below is a sample of our most recent publications which covers our work on deaths in custody:
   - Stolen Lives and Missed opportunities: The deaths of young adults and children in prison (March 2015)
   - Deaths in mental health detention: An investigation framework fit for purpose? (February 2015)
   - The deaths of children and young people in custody: the need for an independent review (January 2014)
   - INQUEST submission to the Home Affairs Committee Inquiry into Policing and Mental Health (May 2014)
   - Preventing the deaths of women in prison (June 2013)
   - INQUEST briefing on deaths in police custody for debate on police procedures and mental health (November 2013)
   - Fatally Flawed (October 2012)
Learning from Death in Custody Inquests: A New Framework for Action and Accountability (September 2012)

Dying on the Inside - Examining women’s deaths in prison (2008)


In the Care of the State? – Child deaths in penal custody in England & Wales (2006)

The health and social care needs of individuals in secure settings – overarching points

In this short submission we have highlighted issues where we feel we can best offer our expertise based on our unique overview of the investigation and inquest process. The provision of adequate, timely and appropriate healthcare in secure settings is an essential element of Articles 2, 3 and 8 compliance of the ECHR. This is also supported by the NHS England’s commissioning intentions to ensure parity of access to, and provision of, public healthcare across the secure estate and in the community. INQUEST’s specialist casework has revealed systemic failings in healthcare provision, such as the treatment, support and the protection of men, women and children held in secure settings.

It is well documented how imprisonment/detention by its very nature increases the risk of suicide and is damaging to well being. As noted by the CQC, a detained individual is dependent on others for their physical and mental healthcare, and because of this they are in a highly vulnerable position. Their vulnerability and circumstances are influenced by the quality of the regimes, adequacy of healthcare resources and the response of staff. Furthermore, due to a growing elderly prisoner/detainee population, along with a large number of those suffering from poor mental health and underlying medical conditions, access to high quality mental and physical healthcare is a vital safeguard.

Based on our extensive work with families whose relative has died in a detained/custodial setting, our casework has revealed multiple concerns about inadequate and inappropriate healthcare and medical treatment:

- Communication breakdown between different prison/IRC/YOI\(^1\) and healthcare staff, across establishments and with statutory bodies outside secure settings
- Inadequate healthcare and failure to properly treat medical conditions, such as epilepsy, diabetes, asthma, and problems with access to medication,
- Lack of staff training in dealing with prisoners/detainees who have complex mental health needs
- Lack of training of healthcare staff about the impact of prison, the right to life and the right of prisoners to be given equal access to healthcare treatment similar to a patient in the community.

\(^1\) IRC: Immigration Removal Centre; YOI: Young Offender Institution
• Poor assessment of vulnerabilities including inappropriate placement and treatment of those with mental health problems, self-harm history and drug/alcohol misuse
• Mental health distress and associated problematic behaviour treated as a disciplinary rather than a medical problem
• Concerns regarding delays or failure to transfer mentally ill prisoners to NHS in-patient hospital care
• Inhuman and degrading treatment of dying and seriously ill prisoners such as the application of restraints and poor palliative care
• Failings in emergency response procedures including access to emergency equipment, timeliness of response and adequacy of medical intervention

The upshot of all these factors is that many of the deaths which have occurred in YOIs, prisons and IRCs were preventable. Due to the absence of a learning mechanism whereby previous institutional failures were not systematically analysed, addressed and rectified, there has been a repetition of deaths raising similar issues across establishments.

INQUEST’s monitoring work looks at the progress of healthcare management and patient safety through narrative findings and Prevention of Future Deaths (PFD) reports, previously known as Rule 43 reports. Narrative findings are the conclusions drawn from inquest juries and can outline the key issues of concern and any individual or systemic failings. PFD reports are the recommendations put forward by the coroner to the relevant authorities regarding the need for policy and practice change in a secure setting. INQUEST notes that despite a series of critical narrative findings and PFD reports, there is no effective method to monitor or audit an action taken in response to coroners’ findings and inquest juries’ conclusions. This is an issue that INQUEST has raised with the National Preventative Mechanism.

There are numerous examples where deaths have occurred in the same institution or in similar circumstances where a PFD report has been made previously. For example INQUEST knows of seven people who have taken their lives in YOI Glen Parva since 2011, and this is despite a number of PFD reports which have echoed similar concerns around poor risk assessments and self-harm prevention procedures.

INQUEST encourages the CQC and HMIP to adopt a multi-disciplinary approach to develop an effective follow-up mechanism. This should ensure that findings and recommendations made as part of the post-death investigation and inquest are integrated, and that issues emerging in narrative conclusions and PFD reports, with both local and national learning potential, are identified. This relates to:

• Mode of investigation and its findings and recommendations, including the clinical reviews and any expert reports which are particularly relevant to the provision of healthcare
• Inquest process findings and recommendations.
• Post-death investigation and inquest action plans/responses.
In all of the above, there is the need for review and follow-up over a specific time period. A systematic analysis of PFD reports and inquest findings should be collated and disseminated to promote cross sector learning and to inform the reasons for inspecting certain establishments.

Lastly INQUEST would encourage the CQC to regularly consult with families – during their inspections, as part of their intelligence gathering work, and in providing feedback to families following their inspections. Our organisation works with more than 200 bereaved families per year, and a key frustration is that families felt that prisons/IRCs did not listen to their concerns, and as a result vital information which may have saved the lives of their relatives was not acted upon. Input from bereaved families is particularly valuable as many have accumulated a strong knowledge of the particular failings in health and social care during their relative’s time in prison. As such they can provide a holistic view of healthcare and treatment. Moreover, many families would like to see evidence of accountability and would benefit from feeling that their views are valued and can help foster policy and institutional change. CQC should be mindful of this important evidence base and seek to include families wherever possible.

In this response briefing, we have answered the questions which fit within our area of expertise to ensure we can best inform this CQC consultation.

1. **Do you agree with the proposal for a joint HMIP/CQC inspection framework?**

INQUEST welcomes a joint inspection framework between HMIP and CQC and hopes that both can work collaboratively to identify health and social care issues among prisoners or detainees before they escalate. Too often there has been a lack of communication between healthcare providers and prison staff and this has led to staff underestimating the risks associated with individuals, particularly those linked to poor mental health and self-harm.

CGL was 22 years old when he took his life in HMP Brixton in 2007 – battling with schizophrenia his distinct needs were not detected at the point of his death. Following a string of transfers he was sent to Brixton and placed in the Health Care Centre. A nurse on the healthcare wing described CGL as suffering from low moods, neglecting his personal hygiene, and in fear of being raped on ordinary location (OL).

Despite CGL’s unstable mental health his ACCT was closed and he was transferred to OL. Moreover no communication of his mental illness and self-harming history was shared with prison officers, leading one staff member to refer to this as an endemic problem: “[a] blinkered culture” between prison and healthcare staff, with each “keeping to its own side”.

Inquests frequently highlight failures in information exchange occurring when individuals are moved between prisons, IRCs and YOIs. Medical documents containing information about a person’s health risks may not accompany an individual during their transfer or there may be severe delays in receiving these documents. Likewise, there have been problems in
obtaining pre-custody healthcare records and we hope that CQC looks at the responsibility of healthcare providers, both outside and inside a secure setting.

Another concern is that due to NHS commissioning of healthcare and other services, and the increasing involvement of the private sector across custodial estate, this has resulted in blurred lines of responsibility and an often antagonistic relationship between different statutory bodies. During inquests this has added to the number of legal teams that are present at inquests and has sometimes been characterised by service providers deflecting blame onto one another.

By way of example, the inquest into Brian Dalrymple, a 31-year-old American man who died at Colnbrook IRC a few days after being moved from Harmondsworth, involved seven properly interested parties:

- GEO Group UK Ltd (private company running Harmondsworth)
- Prime care (private company who provide health care in Harmondsworth)
- Serco Group PLC (private company running Colnbrook)
- Serco Occupational Health (private healthcare providers Colnbrook, which operates as a subsidiary to Serco Group PLC)
- Home Office
- Hillingdon Hospitals NHS Foundation Trust (Brian was referred here due to his dangerously high blood pressure)
- Dr Hamit (locum GP who saw Brian at Harmondsworth)

There are also concerns regarding healthcare failings in prisons, YOIs and IRCs, such as the inability to treat existing health conditions in secure settings, and how this compares with the better quality of healthcare which is provided in the community.

Jason Lawson died of sudden unexpected death in epilepsy at HMP Stocken in 2013. During his incarceration, he was regularly non-compliant in taking his antiepileptic and antipsychotic medication. This was frequently noted in his Inmate Medical Record (SystmOne). There were also a number of entries regarding Jason’s inability to understand the importance of taking his medication and inability to rationalise the consequences of not taking it. His prescriptions were not reviewed to ensure that they were being taken or renewed in a timely manner, leading to long gaps in him being prescribed his medication. At the inquest, healthcare staff gave evidence that there was no active system to ensure lapsed prescriptions were reviewed.

Other issues concerning the administration of medicine were also noted. For example, while medication prescription should only have been managed by a healthcare professional, and despite concerns expressed by prison staff, prison officers were often allocated to this task as there was no provision for out-of-hours nursing staff at the prison.
2. Do you have any comments on the assessment framework of KLOE, prompts and characteristics set out in appendix A?

The five key measures of assessment (safe, effective, caring, responsive, and well-led) offer a good framework for identifying the quality of healthcare in secure settings.

Safety

Too many deaths reveal concerns regarding the failure to protect and keep safe vulnerable prisoners and detainees. INQUEST’s research has documented numerous cases where extremely vulnerable individuals at risk of self-harm did not have the right care or treatment and their level of risk was misjudged. Inquest findings frequently comment on failures in basic training in self-harm prevention and management, where staff do not have the requisite skills to make an appropriate judgement on an individual’s level of risk.

Moreover, there has been an over-reliance on prisoner’s self-reporting of their wellbeing - as opposed to making assessments based on the individual’s medical records or known vulnerabilities.

Steven Davison was 21 years old when he took his life at HMYOI Glen Parva in 2013. He had suffered from severe mental health problems and was diagnosed with a Personality Disorder whilst spending time in a psychiatric unit prior to custody. Steven had carried out a number of suicide attempts which included jumping out of windows and overdosing.

Steven entered the prison system with a self-harm and suicide warning form highlighting his risks. However, the initial assessing nurse did not consider Steven to be at risk of self-harm or suicide despite this information. It emerged during the inquest that the nurse had not been trained in the Assessment, Care in Custody and Teamwork (ACCT) procedures (a system used for prisoners at risk of self-harm) at the time and that she had only received the training in August 2014 by which time she had worked at the prison for 2 years.

The PPO investigation into the death also highlighted key issues around vulnerability and failings in recognising risk factors. These included Steven’s long history of poor mental health and self-harm and the fact that it was his first time in custody.

At the inquest, the jury recorded that Steven’s individual needs, risks and vulnerabilities were not properly assessed, understood or recorded in line with the ACCT process. For example on 25th September 2013, four days before Steven took his life, Steven’s girlfriend had ended their relationship and he was also informed that his grandfather had died. Both of these serious occurrences occurred immediately after Steven had used a lighter to self-harm, yet no ACCT case review was carried out. The jury was also critical of the lack of continuity in Steven’s care; that information was not passed on to the appropriate individuals, and that the frequency and recording of observations was inadequate.

Detainees/prisoners have a complex set of needs, which include severe mental health problems, histories of substance misuse issues, abuse and self-harm, yet their symptoms are
often managed through increased discipline and segregation and this has often led to further isolation. INQUEST’s research has documented a number of cases where healthcare staff have been mistrustful of an individual’s reporting of emotional distress.

Alex Kelly was 15 years old when he was found hanging in his cell at HMYOI Cookham Wood in 2012. He was a troubled and vulnerable child who had suffered serious sexual abuse by a member of his maternal family and was placed in care by age five.

On the evening of 24 January 2012, whilst in prison, Alex was clearly in a heightened state of distress, having had an emotional telephone conversation with his foster parents. He had also made a disclosure to a prison officer about his childhood sexual abuse for the first time. The frequency of his observations was increased but he was later found hanging from the locker in his cell by his shoelaces.

In the coroner’s PFD report she expressed concern about the prison staff’s response to Alex’s self-harming behaviour, commenting that “specific acts by Alex were seen as obstructive/challenging behaviour rather than signs of distress or a means of communicating that he needed help”. She also expressed concern about Alex’s entry into custody without the benefit of a psychiatric assessment, noting that: “I am aware of the deaths of a number of other children in custody who similarly had not had forensic psychiatric assessments”. Had he had a psychiatric assessment, Alex may well have been diverted from custody and subsequent fatal actions.

Effective

INQUEST’s casework has documented evidence of poor training and knowledge of effective care and treatment. Protocols are often misunderstood or are not adhered to, leading to life threatening practices. For example, there have been several issues around the delay in emergency response procedures and the absence of appropriate healthcare equipment.

Muhammed Shukat died at Harmondsworth IRC in 2011. The inquest jury found that neglect failures on the part of both health care and immigration detention centre staff contributed to the death of Muhammed Shukat at Colnbrook IRC. The nursing staff and custody officers did not respond and did not call emergency services as soon as the alarm was raised by his roommate at 5.30. Muhammed’s roommate pressed the emergency button in their cell 10 times to get help for him as he was passing in and out of consciousness and complaining of bad chest pains.

Muhammed was told that he could see the centre’s doctor at 8am by which time he had a cardiac arrest. When staff had realised that his heart had stopped there was a delay of around 15 minutes as the defibrillator was missing from the emergency kit and another one was faulty. Finally a third defibrillator in working order was found.

Caring
Many of the families with which INQUEST works have described the uncaring approach and treatment by some prison/IRC and healthcare staff at a time when their relative was extremely vulnerable. They also describe how they have often faced barriers in giving information about their relatives’ healthcare needs and have not been consulted or informed about a deterioration of their relative’s physical or mental health. Their lack of involvement has often meant that they could not prevent health issues from escalating.

Likewise the healthcare needs of prisoners/detainees are not always given due priority because there is a preoccupation with security concerns i.e. a focus on detaining individuals as opposed to responding to their immediate healthcare needs. This has become increasingly problematic with the rising number of older prisoners; many which have multiple health issues linked to disability, chronic conditions and cognitive impairment. Despite this acute level of vulnerability, there have been cases where elderly prisoners have not been treated with dignity, particularly at times when they are receiving treatment or dying.

Alois Dvorzac was an 84-year-old Canadian man suffering from Alzheimer’s who died in hospital after becoming ill at Harmondsworth in 2013. Alois was initially held at Gatwick airport after a doctor declared him unfit to fly and was sent to Harmondsworth. After spending a brief period at the IRC, he was said to have been ‘extremely distressed’ before being rushed to hospital following a suspected heart attack. He was restrained in handcuffs for five hours before his death and the handcuffs were only removed after his heart had stopped as doctors attempted resuscitation. Commenting on Alois’ death, one doctor at Harmondsworth said ‘this person was extremely vulnerable, he was frail, he should not have been there in the first place, let alone to be detained for such a long while”.

Alois’ case is part of broader pattern, where individuals suffering from severe health problems have been restrained. Some other examples include a prisoner, Michael Tyrrell, 65, who was dying from cancer and too weak to move; 22-year-old Kyal Gaffney, diagnosed with leukaemia, who had suffered a brain haemorrhage; and Daniel Roque Hall, 30, suffering Friedreich's ataxia, a wasting disease that has left him barely able to use his arms or legs. All three were chained in hospital and guarded by three prison officers.

Responsive

INQUEST welcomes CQC’s commitment to ensure the needs of particular groups are catered to. Characteristics such as age, gender, disability, race etc. can have a profound impact on a person’s level of vulnerability.

For example INQUEST’s report, Preventing the deaths of women in prison: the need for an alternative approach\(^2\), has highlighted the high rates of self-harm and drug misuse among women. Despite this, there has been a systemic neglect of women’s physical and mental

health; inadequate healthcare provision; and inappropriate drug detoxification and management of drug problems.

In 2010 Sarah Higgins died of a drug overdose at HMP Bronzefield. Her death was the first of two deaths in worryingly similar circumstances at the prison within a ten month period.

The key issues concerning Sarah’s death included the failure to communicate and act upon risk information contained in a Prisoner Escort Record (PER) and which accompanied Sarah when she was taken from court to HMP Bronzefield the day before her death. The PER contained risk indicators including a real concern that she may have concealed drugs, the fact that she had been on constant watch at the police station and details about medication that had been given.

At the inquest the jury found that procedural failure and inadequate training contributed to the death of Sarah Higgins. When she died a kinder egg containing various drugs was found in her clothing.

Serious concerns were also raised about the failure to provide the prison healthcare staff with medical information which came within the ‘current and relevant risk’ section of the PER. Healthcare staff gave evidence that they did not routinely receive medical documents arriving with new prisoners and some were unaware that PERs which accompanied prisoners could contain health information.

The inquest found that on the balance of probabilities had this information been passed to prison healthcare the medication prescribed and administered to Sarah would have been different, and that Sarah should have been located within “healthcare” where facilities were available for closer monitoring and observations”.

Well-led

There needs to be a co-ordinated response by the investigation and inspection bodies to develop their post-inquest functions. The jurisdiction of the coroner ceases when a finding is made and a response to a report is received, even if it is felt that the response was inadequate. The current level of resourcing means that coroners are not able to continue this monitoring and follow-up role.

The Prison and Probation Ombudsman and HMIP thematic reports do provide examples of good practice, however there is no systematic case by case timeline of actions taken in response to the individual death and how this impacts nationally and its relevance in terms of cross-sector learning.

Because of this lack of accountability, failings across the detained/custodial sectors become endemic and suggest a culture of complacency. INQUEST’s report, Learning from Deaths in Custody Inquests: A New Framework for Action and Accountability, analysed a sample of
Prevention of Future Death reports sent to prisons between 2007-09 and noted repeated areas of concern:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Rule 43 reports (42)</th>
<th>Narrative verdicts (36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>14 (33%)</td>
<td>9 (25%)</td>
</tr>
<tr>
<td>Staff record-keeping</td>
<td>21 (50%)</td>
<td>4 (11%)</td>
</tr>
<tr>
<td>Staff training</td>
<td>23 (55%)</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Drugs</td>
<td>6 (14%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Use of restraint</td>
<td>3 (7%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Inadequate health care</td>
<td>20 (48%)</td>
<td>8 (22%)</td>
</tr>
<tr>
<td>Poor mental health care</td>
<td>4 (10%)</td>
<td>8 (22%)</td>
</tr>
</tbody>
</table>

Repeated recommendations pointed to a need to resolve communication failures, address inadequate record keeping and provide staff training on healthcare needs within secure settings.

Brian Dalrymple died at Harmondsworth IRC in 2011. Brian was a 31-year-old American man with significant health problems and suffered from an anxiety disorder and schizophrenia. The jury at the inquest into the death of Brian detailed a catalogue of errors in his care and stated that the medical record keeping at Harmondsworth IRC was ‘shambolic’.

In the 6 weeks of his detention there was no psychiatric assessment carried out on Brian, this was despite the Chief Immigration Officer attempting to flag up concerns and Brian’s signs of mental distress. Temporary medical staff working with Brian were not made aware of the separate document management systems maintained by detention officers which would have given insight into his behaviour. Three days before his death Brian was transferred to the Serco run Colnbrook IRC. His medical records did not follow him to this detention centre. Brian died before his appointment to the psychiatrist: his blood pressure caused an aortic rupture.

Moreover the CQC and HMIP must pay more attention to post-death communication, where timely information about the relative’s death or action taken in response to their death becomes an integral part of family liaison guidelines and protocols.

3. Should we consider a single rating for health and social care within a secure setting? Should this be a joint rating with HMIP or a CQC rating? Joint with HMIP/CQC rating

INQUEST believes that the CQC should provide a separate rating system to HMIP’s rating. In INQUEST’s experience, there is significant conflict when it comes to accountability following a detainee’s death regarding who was responsible for their care.

A member from our associate network, Inquest Lawyers Group, is currently representing the family of a man who died in HMP Durham from drug-induced bronchopneumonia. Care UK

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provided the health care and there are issues around nursing staff repeatedly failing to follow policy and take clinical observations after the prisoner was discovered to be under the influence of drugs. INQUEST is concerned that there may be attempts to deflect blame between the prison and Care UK. While healthcare failures are noted above, there may be disputes regarding initial screenings by prison and the absence of a urine test to detect the intoxication of drugs.

While it is important to adopt a holistic approach and to encourage collaboration between services providers, the identification of failures requires a pinpoint analysis of where the problems exist so as to prevent future deaths from occurring.

4. **Do you agree with our proposals for gathering detainees’ experience of care?**
   - Are there any other ways we could gather this information?

We welcome the proposal for gathering detainees’ experience of care. This should not be limited to the time of inspection and should be part of long term engagement plan, as it would allow for a better understanding of problems and trends, and would promote a sense that prisoners’ input is valued.

5. **Do you agree with our approaches to working with national and local organisations?**
   - Is there anything else that we should be doing?

As mentioned, INQUEST believes that families have a crucial part role to play in providing information to CQC-HMIP inspections. They can provide an overview of their relative’s treatment and issues identified from an inquest. There may be practical difficulties in obtaining evidence from families due to problems of accessibility, and so INQUEST could provide a mechanism for feedback or for anchoring the voices of families during an inspection.

INQUEST has a long history of facilitating forums for bereaved families to share their experiences and concerns with key stakeholders. The most recent examples include two family listening day events which we held for the Independent Police Complaints Commission.

6. **We have described how we will gather the views of detainees in advance of the inspection. Do you think this is an effective approach to supporting our work?**
7. **We have described how we will gather information and evidence while on site at the secure setting. Do you think this is an effective approach to supporting our work?**

Question six and seven have been answered together in the following paragraph.

INQUEST welcomes the use of evidence from prisoner councils/forums and focus groups. With regards to the proposed focus groups we recommend careful consideration is given to how participants are chosen. Both self-selection and selection by prison/IRC staff may not provide a representative sample of the prison/IRC population may and lead to bias within
the outcomes. In addition other channels of communication, via articles in Inside Time or broadcasts on National Prison Radio, should be explored for maximum reach.

We also recommend that any documents which are used for feedback should be simple, cater to all literacy levels, those for whom English is a second language and ensure anonymity. Lastly, we suggest that all surveys make special provisions for the monitoring of particularly vulnerable groups (women, young people, and individuals with special educational needs, different nationalities, religious and BAME groups).

Conclusions

INQUEST welcomes the collaborative work of the two inspectorate bodies and hopes that their joint resources and expertise will develop a central oversight role of health and social care in secure settings and help improve patient safety and accountability. One of the most under-used and yet highly valuable sources of information about health and social care in prisons/IRCs is that arising from the investigations and inquests into deaths in secure settings. In order to maximise the preventative potential of post death investigation and for organisations to reflect and learn from them, there needs to be a systematic approach to their collation and analysis. Inspection bodies can play a vital role in reporting publicly on the accumulated learning. To this end the CQC should publish an annual report on prison health and social care in a similar way to that published by HMIP. This could include information on health and social care concerns raised by post death investigations, making recommendations for change and monitoring actions taken at a local and national level. This would act as an important learning awareness model; help to inform organisational changes to policy and practice; and improvements in patient health and safety in secure settings.

Finally, families should be regularly involved, giving them the ability to feed into inspections, whilst also being consulted on proposed actions and the on-going work of the two inspectorate bodies.

INQUEST 2015.