[2017] UKFTT 891 (HESC)

Care Standards

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

[2017] 3126.EA-MoU

Before

Ms Siobhan Goodrich (Judge)
Ms Caroline Joffe (Specialist Member)
Mrs Wendy Stafford (Specialist Member)

Heard on 21, 22 and 23 October 2017

B E T W E E N

RACHEL CORRIGAN (Your Care)

Appellant

and

CARE QUALITY COMMISSION

Respondent

DECISION AND REASONS

Representation:
The Appellant: Mr Simon Gough, counsel.
The Respondent: Mr Rad Kohanzad, counsel.

The Appeal

1. This is an appeal by Ms Corrigan pursuant to section 31 of the Health and Social Care Act against the decision made by a Justice of the Peace who, on 22 August 2017, made an order under Section 30 Health and Social Care Act 2008 cancelling her registration as the provider of domiciliary care services.

Restricted Reporting Order

2. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the service users and carers in this case, so as to protect confidentiality regarding their health.

3. Consistent with this, the names of service users and carers have been anonymised in this decision.

The Background and Chronology

4. We set out below a summary of the basic background/chronology.

i. The Appellant was registered on 21 September 2016 to carry out the regulated activity of personal care from the location, Your Care, Unit 29, Price Street Business Centre, Price Street, Birkenhead, Wirral, CH41 4JQ. The Appellant employed peripatetic carers to provide personal care to people in their homes.

ii. On Thursday 10 and Friday 11 August Mr Devine conducted an unannounced inspection of Your Care.

iii. Ms Corrigan made a complaint to Ms Challinor, Inspection Manager, to the effect Mr Devine was rude and said that she wanted the inspection to be conducted by a different inspector.

iv. The inspection continued on Monday 14 and Tuesday 15 August 2017 when Mr Devine was accompanied by another Inspector, Mr Adnams.

v. On 16 August 2917, a Letter of Intent was sent to Ms Corrigan regarding possible urgent enforcement action under section 30 or 31 of the Act. Amongst other matters, Mr Tovey, Head of Inspection, made clear that the CQC considered that the Appellant was in breach of multiple regulations. The Letter of Intent also made clear that, in the context of 10 live safeguarding alerts by way of missed calls for 10 service users as at that date, the Appellant's intended absence abroad was a cause for concern. The Commission requested that that Ms Corrigan draft an urgent action plan setting out, how she intended "… (in a short timeframe – the Commission in light of the risks at hand request this by 10am 17 August 2017) to address the concerns the regulator has in relation to the unsafe provision and risks at the service…"

vi. On the same day Ms Challinor sent a copy of the Letter of Intent to Ms Walker, the Contracts Lead for Domiciliary Care Services at Wirral Council. In light of the concerns identified Wirral Council decided to provide support including oversight of the service.

vii. On 17 August 2017, Ms Corrigan responded providing assurances and an action plan, one of the key points being that an alert system had been put in place on 16 August "which will come through to the manager and supervisor and will be picked up immediately".

viii. The Respondent decided that at that stage it did not need to seek an urgent court order cancelling the provider's registration, as the Wirral commissioning bodies were working with the provider to mitigate the urgent risks.

ix. On 18 August 2017, the Respondent received information from the Wirral commissioning bodies that the assurances given by Ms Corrigan in her response were not in place and that staff members left in place to carry out

the regulated activity in Ms Corrigan's absence, whilst on annual leave, were unfit to do so.

x. On 21 August 2017, Wirral's joint Clinical Commissioning Group and Wirral Local Authority informed the Respondent that their level of concern had increased to such an extent that they would support an urgent application being made by the Respondent to the Magistrates' Court to seek to urgently cancel the provider's registration.

xi. On 21 August 2017 the Respondent served the Notice of the Application on Ms Corrigan. On 22 August 2017 it made an application in the Liverpool & Knowsley Magistrates' Court for an Order cancelling the provider's registration.

xii. On 22 August 2017 the District Judge heard evidence from both Ms Challinor, the Inspection Manager, Mr Adnams, Inspector, and NB who was employed by the Appellant as an administrative assistant. Ms Corrigan was not present as she was on holiday but she was represented by counsel. Mr Devine was also not present as he was on leave. The District Judge made an order under Section 30 Health and Social Care Act 2008 cancelling the provider's registration on the grounds that he considered that a failure to do so would give rise to a serious risk to a person's life, health or well-being.

The Hearing

5. We received and read two large indexed and paginated bundles which included a number of witness statements on both sides as well as skeleton arguments from both Counsel. In the course of the evidence we received further documents for which an agreed list has been provided pursuant to direction. We heard oral evidence from Mr Devine, Ms Challinor, Mr Adnams, Ms Corrrigan and Mrs Corrigan senior. Thereafter we received sequential written submissions from Mr Kohanzad and Mr Butler.

6. We will summarise below the main aspects of the respective position of the parties.

The Respondent's case

7. In summary the Respondent's position is that:

i. the evidence showed there were numerous occasions where service users ("SUs") were not receiving the calls that had been identified as necessary under the Care Act 2014. Amongst other matters: the Appellant's computer system recorded 205 missed calls in one of 11 geographical regions covered; she had no way of monitoring when a call was missed or was likely to be missed and why; there was no evidence that she had investigated why there had been any missed calls and what the consequences to the SU were; a number of calls were being received so late that risks were being posed to the well-being of the SUs; there was no audit of the completion of calls; staff rotas showed calls crammed together, showing multiple calls at one more than one

time of day, suggesting that the rotas were deliberately drafted knowing that care would be provided late, not at all or call lengths would be cut short; staff rotas showed multiple unallocated calls – creating the risk of missed calls; rotas did not always show the correct call information; rotas did not appear to be created sufficiently in advance of the care being provided: the Appellant did not accurately record who was available to work for it or the number of carers; the Appellant did not employ enough staff and there were not always sufficient staff at all times.

ii. These were not abstract procedural errors but created a serious risk to the life, health and well-being of service users who were vulnerable because of their age, health and needs. The Appellant's failures in respect of missed calls were compounded by breaches of the Regulations including that: the Appellant failed to ensure that there was proper management cover in place whilst she was on holiday; staff were working for her without a recruitment file, references, up to date DBS checks or Schedule 3 information; there was insufficient training in the areas of medication, moving of people, nutrition, hydration and safeguarding of vulnerable adults; there was a lack of evidence of consultation, or the obtaining of consent, regarding SUs' care; and failure to notify the CQC of any notifiable incidents despite there being a number.

iii. One does not have to be a medical expert to see that a failure to provide the type of care being provided to the SUs, including feeding people who struggle to feed themselves, getting people in and out of bed who cannot do so themselves, and ensuring that the SU take sensitive life affecting drugs, such as warfarin, is likely to create a serious risk to the SUs' lives, health and well-being.

iv. Nothing that Ms Corrigan has done since the District Judge's decision inspired any confidence that the situation would be any different if the appeal was allowed.

The Appellant's case

8. In essence in her lengthy witness statement the Appellant challenged the findings of the inspection. Given the main focus in this appeal we summarise here her case in relation to missed calls.

   i. In March 2017 she began to have problems with one employee, JH, who did not log her calls with the result that they were shown as missed although they had been completed.

   ii. In June 2017 whilst she was away on holiday for 5 days JH was assistant manager. On her return other employees, TA and MG, told her that JH hardly attended any of her calls and had delegated them to an already depleted work force. In the event following an investigation conducted by Peninsula Group Limited she dismissed JH in late July. The Appellant was

informed by other staff members that JH was trying to sabotage Your Care and was trying to set up on her own.

iii. If any calls had been missed the SU's would have contacted her (para 46).

iv. During the inspection she had explained that calls were not missed and explained the problems she had had with JH.

v. The assertion that Your Care missed a high number of calls is incorrect. There are various reasons why a call may be shown as missed on the system report such as staff not clocking in, mobile phones being out of battery and the switch over of cover between providers.

vi. Prior to 16 August 2017 she manually checked the system every day to check for missed calls.

vii. After 16 August 2017 she did receive a few alerts when on holiday in Turkey as she had implemented an alert system as part of the Action Plan, but these missed calls were due to social services informing agency staff not to attend as Your Care had been shut down. She made sure that staff covered all calls so none were missed though some would have been late.

viii. 194 of the 205 missed calls shown were attributable to JH not clocking in.

ix. Staff were sometimes assigned to numerous calls at the same time and this was completely practicable and achievable because social services gave a lee way of half an hour either side of appointment times.

9. We need not set out all the written submissions as these are a matter of record but note that the Appellant's position is that:

   i. Whether or not she has breached the regulations under the Health and Social Care (Regulated Activities) Regulations 2014 is irrelevant when determining whether there was a serious risk to a person's life, health or well-being. The only issue is whether there was a serious risk to a person's life, health or well-being. This is a very high threshold.

   ii. A 'risk' in the context of s.30 of the 2008 Act must mean the probability of a harmful event occurring." A 'serious risk' must mean there is a significant probability that harm could result in death, which could result in significant disability or incapacity, or which could result in hospitalisation (health or well-being).

   iii. The Respondent relies on multiple hearsay. A statement from Ms Roberts has not been provided. The Respondent has not produced evidence from service users. The Respondent has not exercised its powers under section 64 to require the Appellant to provide information documents or records. Mr Devine and Mr Adnams purport to give opinion evidence on

medical issues when they are not medically qualified. The Respondent has not adduced any evidence to show that the Appellant or any of her staff intended to cause harm. The inspection was targeted following the receipt of information but evidence had not been provided as to the provenance of this information.

iv. Following receipt of the Letter of Intent the Appellant put in place an action plan which addressed missed calls, service users not getting their medication on time, DBS checks and the qualifications and experience of staff. The plan was unequivocally and unconditionally agreed on 17 August 2017. The Respondent was therefore satisfied that "immediate risks" were being mitigated.

v. The only factual evidence provided to as to what happened thereafter is provided by Mrs Walker from the council and did not justify cancellation. The information provided by Mrs Walker (as set out in her witness statement) could not, as a matter of fact or law, reach the high threshold of significant risk of harm. Cancellation was unnecessary and wholly disproportionate to the circumstances in existence after 17 August 2017.

vi. There were alternatives available to the Respondent such as conditions or suspension. The decision was not reasonable, justified or proportionate.

The Legal Framework

10. The Respondent's main objective as prescribed by statute is to protect and promote the health, safety and welfare of people who use health and social care services (section 3(1) of the 2008 Act). The Respondent must have regard to the need to protect and promote the rights of people who use health and social care services (section 4(1(d)). They must also ensure that action by them in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed (section 4(1)(e)).

11. There is a range of measures that are available to the Respondent in seeking to discharge its functions under the Act. This appeal concerns the use of the Urgent procedure for cancellation under section 30. This provides as follows:

"(1) If—
(a) the Commission applies to a justice of the peace for an order cancelling the registration of a person as a service provider or manager in respect of a regulated activity, and

(b) it appears to the justice that, unless the order is made, there will be a serious risk to a person's life, health or well-being, the justice may make the order, and the cancellation has effect from the time when the order is made.

12. An appeal against a decision of a Justice of the Peace is made pursuant to section 32(1)(b) of the 2008 Act and must be brought within 28 days of the decision (section 32(2) of the Act).

13. On consideration of the appeal First Tier Tribunal may confirm the decision or direct that it is not to have effect (section 32(4) HSCA 2008).

14. The Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 provide that:

    15 (2) The Tribunal may—

    (a) admit evidence whether or not—

    (i) the evidence would be admissible in a civil trial in England and Wales; or

    (ii) the evidence was available to a previous decision maker; or

    (b) exclude evidence that would otherwise be admissible where—

    (i) the evidence was otherwise provided in a manner that did not comply with a direction or a practice direction; or

    (ii) it would otherwise be unfair to admit the evidence.

The Burden and Standard of Proof

15. In so far as any past facts in issue the Respondent bears the burden of proof and the standard is the balance of probabilities.

16. We have considered Mr Butler's submissions on the standard of proof regarding the risk assessment under section 30. We agree that the draconian nature of a cancellation order is such that a much higher threshold is required than in other parts of the Act i.e. such as that engaged in the power to suspend.

17. The ultimate issue involves a judgement as to the significance of risk on the basis of all the material before us, including any findings we may make in relation to past facts. The Respondent bears the burden of satisfying the Tribunal that "it appears that, unless the order is made, there will be a serious risk to a person's life, health or well-being".

18. In his submissions Mr Butler refers to hospitalisation or significant disability being necessary to establish "serious risk". In our view Section 30 makes clear that serious risk to well-being (as an alternative to risk to life or health) is sufficient to engage section 30. We consider that the words in section 30 are clear and need no amplification or gloss.

19. Mr Butler referred us to the decision of the Court of Appeal in Jain and another v Trent Strategic Health Authority [2008] QB 246, where Lady Justice Arden said at para 79:

    "I have not found in any of the authorities to which we have been referred any explicit discussion of what is meant by the requirement in section 30(1)(b) that there should appear to the magistrate to be a serious risk to the life, health or well-being of residents unless the order is made. However, in my judgment, it is implicit in that requirement that there should be a significant risk that the

residents will suffer harm within the time scale that would otherwise be required under the ordinary procedure provided for by sections 28 and 31 to 33. That question involves making a judgment on a number of matters including the vulnerability of the residents, the seriousness of the shortcomings of the home and how long it would take for the proprietors to put them right. The last-mentioned matter would involve not only technical knowledge about any work needing to be done and the availability of contractors or staff but also knowledge built up over a period of time about the ability of the proprietors to respond to calls to action. It is noteworthy that the powers given to the RHT on appeal do not include the payment of any compensation to the registered person if his appeal is successful."

(our own bold)

Our Consideration and Findings of Fact

20. It is common ground that we are required to determine the matter de novo and make our own decision on the evidence as at today's date. This can include new information or material that was not available to the District Judge. It is, for example, open to any appellant in any given case to rely on evidence to show that the evidence was wrong and/or that the issues have since been addressed. Here, the Appellant's primary case is that there was no evidence of serious risk of harm in the first place. Further, her case is that the Respondent had agreed her action plan, and that it mitigated the risks, and there was therefore no good reason to make the application for a cancellation order.

21. The redetermination in this appeal includes consideration of the more detailed evidence provided by both sides in this appeal as well as the oral evidence which has now been subjected to cross examination over three days. We will not set out the oral evidence but will refer to parts of it when giving our reasons. We have considered all the evidence and submissions before us.

22. It is important to recognise that an urgent cancellation order lies at the top of the hierarchy of possible steps that can be taken under the Health and Social Care Act 2008. That, in itself, is recognised by the requirement that a cancellation order can only be made if it appears to us that serious risk of harm to life, health or well-being exists. It is agreed that this is a high threshold. Applying Jain, the overarching question involves making a judgment on a number of matters. In our view in the circumstances of this case this must include consideration of the vulnerability of the service users, the seriousness of the alleged shortcomings in the service provided by the Appellant, and whether the risks had (or could have) been mitigated within the time scale involved by other less draconian measures. Applying Jain this last aspect, in particular, may require consideration of the circumstances underpinning any facts that we have found proved, as well as consideration of matters such as Miss Corrigan's response to the matters raised as well as her willingness and/or her capacity to address concerns.

23. Before evaluating the issue of risk, it is necessary to make findings in relation to the factual circumstances that led to the Letter of Intent, the Appellant's

response, her Action Plan and the events that led to application for urgent action. We find that the basic facts in terms of the overall chronology of events are as set out in para 4 above. We will make additional findings below.

24. In our view what lies at the very heart of Miss Corrigan's case before us is that she does not accept that were any serious issues regarding her ability to provide the commissioned service. Her case is also that the wider range of matters that concerned Mr Devine and Mr Adnams regarding multiple breaches of the regulations are of no relevance to the risk assessment that the Tribunal has to undertake.

25. We find that Mr Devine 's evidence in relation to the inspections was reliable. He made contemporaneous notes which we find were an accurate account of what he saw and observed and what he was told. The accuracy of his account is supported by the fact that he made notes of feedback he gave to Ms Corrigan which she signed as a record of the feedback given. We will return to the detail in due course. Ultimately the issue of the magnitude of risk is for the panel to assess but we state here that we found Mr Devine was an impressive witness who, when challenged, was well able to explain the various sources of the evidence that he considered supported the views that he had reached.

26. Mr Adnams was also an impressive witness who made notes of key matters. We accept his account as to what happened at the inspection visits.

27. Ms Challinor was not involved in the Inspections themselves but played a key role in the decision making. We will return to this in due course.

28. We intend to consider the evidence regarding some aspects of the inspection as it unfolded over the course of the four days.

Thursday 10 August 2017

29. Mr Barry Devine, a CQC inspector, arrived at the premises of Your Care at 10am on 10 August to carry out an inspection. The visit was unannounced. Whilst waiting in the office he heard NB taking phone calls and heard her say to one caller, "They should be on their way". The inference we draw was that this was a SU or SU family member calling up and asking where one of the carers were. The unchallenged evidence of Mr Devine was that NB told him that another caller, Ms OM, was also asking where the carers were.

30. At Mr Devine's request the Appellant printed off a list of the service users. This had 76 entries BD/01. Ms Rachel Corrigan and Mr Devine went through the list together eliminating incorrect information and people who were no longer supported by Your Care. By means of this process Mr Devine noted that there were 51 SUs.

31. In her oral evidence, Ms Corrigan contended that the number of SUs was actually 49. If that is correct it reinforces that on 11 August 2017 Ms Corrigan was unable to show how many people Your Care was caring for.

32. Mr Devine's concern was whether there were sufficient staff to make visits to the number of service users. Ms Corrigan was not able to provide him with a definitive list of staff. A list showing 22 staff members, including herself and the administrator, were provided to Mr Devine. When Mr Devine asked for information regarding staff member LB whose file he had looked at, Ms Corrigan told him that she was not in fact a staff member, even though she was on the staff list.

33. Ms Corrigan and Mr Devine went through the staff list on the system and he noted that six agency staff members were on it. There was also one staff member who had left Your Care and two long standing staff members who were missing from the list. We agree with the Respondent this shows that the simple process of identifying how many workers there were to deliver the commissioned care packages was not straight forward.

34. The local authority (LA) had informed Mr Devine that Ms Corrigan had informed the Quality Assurance team that she employed 21 people, used another 4 agency staff and had 5 staff starting the week commencing 7 August 2017. Even on the Appellant's case before us the number of staff (including agency staff) was much less than 30**.**

35. We find that Mr Devine's efforts to obtain information about the numbers of service users and the numbers of staff indicated that there was a significant issue as to whether there were sufficient numbers of carers to provide the commissioned services.

36. During the inspection, Ms Corrigan informed Mr Devine that Your Care did not have any missed calls despite the large volumes of missed calls shown by the One Plan system.

37. Mr Devine asked Ms Corrigan for a print out of missed calls from the system for the previous three months. Ms Corrigan gave him a print out which contained information about 205 missed calls from 1 May 2017 - until 10th August 2017. We find that this was actually a print out for only one area out of the 11 across the large geographical area for which the Appellant had contracted to provide care packages. In our view the picture revealed in respect of the limited information provided is startling. In her witness statement Ms Corrigan attributed 194 of the 205 missed calls to JH. On her own evidence JH was sacked following an investigation which concluded on 13 July 2017. We will return to the evidence about JH later.

38. Ms Corrigan's case, however, is also that that there are a variety of reasons why calls would show as missed, which included staff having no phone and the phone being broken. When this was examined in oral evidence, it was clear that:

(i) staff were provided with a phone by One Plan;

(ii) if the phone was broken, One Plan would replace it within a day or two;

(iii) Your Care had spare chips that could be placed in a SU's file if it was not being detected by a phone;

(iv) staff had to have their phones with them in order to know where their calls were; and

(v) the system updates only ever provided a minor and temporary disruption.

39. Ms Corrigan also suggested that a call may not be recorded because of a poor signal but when examined on the matter, she conceded that there were no SU's properties' that had no signal.

40. Ms Corrigan's essential position in evidence was that every single case that the One Plan system recorded the call as missed arose because the carer did not tap their mobile phone (provided by One Plan) on the file when arriving at the property. Her evidence was that if the call was late, then it would be recorded as late. Her case was that all of the missed calls in the bundle were therefore where a carer had not "tapped in" on arrival. She relies on notes recorded on One Plan as evidence that a carer had attended on occasions when the call was noted as missed.

41. In our view it is clear that a note can be placed on One Plan at any time from any location, whereas for the system to show a call as having been completed, the mobile phone of the carer has to be placed on the SU's file i.e. carer has to be physically present in the SU's home.

42. Another problem on the evidence before us is that documents showed that payments to employees were generated in line with their attendance as recorded on the One Plan system. It is difficult to credit that any employee would routinely not register her presence in the SU's home. It is also difficult to credit that JH would have failed to log in on calls on 194 out of 205 occasions.

43. In her witness statement Ms Corrigan said if there had been any missed calls the SUs (clients) would have contacted her. We noted that the Appellant also had said in her statement that she had manually checked missed calls on a daily basis. If this was so one might expect that she was aware of the problems that were being reported by SUs and their families.

44. In the first day of the inspection Mr Devine asked Ms Corrigan about the care provided to HB and PN because those records were in front of him. HB's records included the notes concerning17 June 2017 from HB's daughter as follows:

> "No one came Saturday morning 17.06.17 or lunch time. Mum rang me at 12:45 to say she was hungry and hadn't had tablets. When I got here house manager [from sheltered housing] had made some toast and tried to ring Rachel. I have given 3 tablets at 1:30. 6:00 Gave her tea and tablets, left at 6:40."

> The second note referred to the next day, Sunday 18 June 2017. It stated:

> "No carers came lunch time. I left at 7:15 (pm) after giving mum lunch + tea + tablets. I hope you come in the morning because I am at work full time and mum is diabetic + needs to eat + have her tablets. This is upsetting her. "

45. Ms Corrigan's account was that she looked at One Plan, saw that there were notes on the system and concluded that the calls had been made. We agree that this does not amount to anywhere near a proper investigation of this matter. A care provider who was investigating missed calls would have wanted to get to the bottom of the inconsistency between the manuscript notes and One Plan. A care provider carrying out such an investigation would also have noted the discrepancy between the daughter's account that her mother was diabetic and the fact that the care plan did not reflect this. HB was due to have three calls daily of 30 minutes length: morning, lunch and tea, and the manuscript notes indicated that over the weekend of 17 and 18 June 2017 HB only received one of the six calls commissioned.

46. We noted also that Ms Corrigan conceded in her evidence that there were occasions on the MAR (medicines administration record) charts when she had visited HB as a carer and had not recorded providing her with medication.

47. Gaps in PN's MAR charts can be seen at C395 and Ms Corrigan was unable explain this to Mr Devine.

48. Mr Devine's evidence was he inspected all the personnel files made available and found them to be incomplete. The contents of the few files he saw gave rise to concern. The file for MG, for example, showed a verbal reference marked as, "ref was taken over the phone by Rachel". The reference was dated March 2014, which is before Your Care was registered in September 2016. There was also an induction checklist for MG which was dated 01.04.14. The employee portfolio showed a start date of employment as 03.05.14. Furthermore, an employee declaration of suitability was dated 03.03.14. and there was a contract showing employment began on 01.04.14.

49. Ms Corrigan asserted in oral evidence that she had full personnel files for each employee which included evidence of training in them. She said that she could not understand why it was that Mr Devine did not see them. She went on to say that she still had the personnel files in storage. These were not provided for the hearing. We accept Mr Devine 's evidence that Ms Corrigan told him on 10 August at 15:24 that she could not find any training records. She logged into the website of Peninsular Business Services and started looking on this site, but was unable to find any training records for staff.

50. Mr Devine asked Ms Corrigan about her staff's DBS checks. She showed Mr Devine the "Mayflower system" [BD675], which only showed 9 staff. AT had no DBS information. MW had a DBS from Lavoro Care dated 17.05.17 and SF had a DBS dated 15.09.15 from Care Plus. Ms Corrigan told Mr Devine that these three staff had portable DBS. Whilst it is quite possible that some staff have portable DBS certificates, there was no evidence in the bundle that Ms Corrigan had checked the status of their DBS certificates on line.

51. Before leaving on 10 August 2017, Mr Devine gave Miss Corrigan an initial feedback and filled out a feedback form which she signed. The feedback outlined poor record keeping, poor organisational information and poor day-to-day record

keeping in the care of PN and HB. Mr Devine informed Ms Corrigan that he was returning the following morning. His return provided Ms Corrigan with the opportunity to address his concerns and to demonstrate that she ran an effective service.

Friday11 August 2017

52. When he arrived at 10:30 am on Friday 11 August Mr Devine could not gain access. He knocked repeatedly at the door. Over the next hour he called the office number for Your Care and the emergency number several times without answer. Mr Devine eventually called Lynn Roberts from the LA who phoned Ms Corrigan and left her a message. Ms Corrigan then called Ms Roberts back shortly after this and told Lynn that she was at the office of Your Care. Mr Devine went straight back to unit 29 and Ms Corrigan let him into to the office of Your Care at 11:54.

53. It is common ground that Ms Corrigan told Mr Devine that she had been on moving and handling refresher training course with a group of staff. Mr Devine said that she informed him that she had the training with "Tidal Training" from 08:45 until about 11 :30. Mr Devine said that he did not see a group of people leaving the business centre. His evidence was that he was watching because he wanted to speak to staff.

54. We find that Ms Corrigan told Mr Devine that Tidal Training were coming back on 21 September to train a second group of staff. Mr Devine contacted Tidal Training and they said the training had indeed been booked for 21 and 22 September 2017 but not for 11 August 2017. It is clear that the September training was only booked at 10.07 on 11 August. In oral evidence, Ms Corrigan initially contended that she must have booked the training by email but when confronted with the note which records a telephone call, she suggested it was only a short call she made whilst she was on the training session. On the first day of the hearing it was suggested on the Appellant's behalf that she would provide documentary evidence that she had been in training on the morning of 11 August. On the second day of the hearing she produced an invoice. However, the training company on the invoice was called up and they confirmed that they did not provide face to face training on 11 August. Ms Corrigan then suggested the training was with another provider and that she could produce evidence. That evidence was not forthcoming by the end of the hearing.

55. Given his mounting concerns regarding the capacity of Your Care to provide adequate cover for the service users Mr Devine asked Ms Corrigan for the rotas for the weekend Saturday 12 and Sunday 13 August 2017, which were given to him [C427]. Mr Devine provided his own summary of some of the calls at C479, which shows that one carer was on the rota to cover three calls at 8.30am, two at 9am, three at 1pm, and five calls at 5.30pm. In the morning there were three different areas of Wirral to be covered by about 20 miles or 30 minutes travel. The obvious consequence of such call cramming is that calls are either cut short, are missed or are very late.

56. In these proceedings part of Ms Corrigan's response to the evidence to the large number of missed calls was to place the responsibility on JH, a disgruntled employee/manager. She said she dismissed JH at the end of July 2017. However, the rota at BD /13 shows JH is on the rota – in three places – for the weekend of 12 and 13 August 2017. Whatever the truth is regarding JH's employment status, we do not accept that any issues with JH provide any or any adequate explanation for the large volume of missed calls evidenced before us.

57. Mr Devine was so concerned with the call cramming and the provision of care over the weekend that he asked Ms Corrigan to email him and Lynn Roberts at the Local Authority with a copy of the amended rotas before the end of the working day. Ms Corrigan sent rotas to Mr Devine and Ms Roberts at about 5pm ("the second rota"); however, even this rota [C519] shows SUs missing from it when compared to the list of SUs shown on BD/02. C519 for example shows that IS was not on the rota.

58. When cross examined about this Ms Corrigan said was that there was in fact a third rota that she sent to LR at some stage after 5pm. That email and attached rota were promised to arrive on the second day of the hearing. Neither were provided. On the third day of the hearing Ms Corrigan produced a print off from the computer system to which she had access.

59. We find that Mr Devine's criticisms of both the first and second rotas were valid. We find that Ms Corrigan raised the issue of the "third rota" in an attempt to deflect attention from the fact that the rota by which service was to be provided over the weekend was deficient for the reasons given by Mr Devine. C858 shows that not only was IS missed from the rota but that she also had three calls that were missed that weekend.

60. One of Mr Devine's criticisms of the second rota was the fact that there were 17 unallocated calls. Ms Corrigan's evidence was that these unallocated calls were ones where the SUs were no longer receiving care/had cancelled rather than where they did not have a member of staff. The feedback form at C485 records the 17 unallocated calls as a criticism. Had those SUs left/cancelled the service, it is likely that Ms Corrigan would have objected to the criticism, but she did not. She said in evidence that she did not believe that she had any option but to sign and did not think she could add her own comments. We consider this unlikely. She is an educated woman who was well able to assert herself by making a complaint about Mr Devine.

61. By failing to compile a rota in advance Ms Corrigan was likely to fail to identify rota problems and therefore likely to fail to take action to overcome such difficulties. She did not consider this to be a problem when discussing the matter with Mr Devine or before the Tribunal. Her confident assertion was to the effect that rotas were often prepared late. That may be so and, in our view, provides some insight into why an extremely large number of missed calls occurred.

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62. On 14 August Mr Devine emailed Ms Corrigan at 09:30 to confirm that he and a colleague expected to be at the offices of Your Care at 11:00 and she replied that the office would be open, but she would not be there as she would be in a meeting. The inspectors arrived at 11 am. Their evidence was that Ms Corrigan did not arrive until 3.30pm and left soon after to make a visit. Her evidence was that she was there much earlier. We consider that their account is reliable. It is clear that both inspectors were more than a little surprised by the fact that they were kept waiting until 3.30pm to see her.

63. Whilst the inspectors were waiting, NB informed them that she could not get onto the computer system as it was down. The evidence of Mr Newsome of One Plan was that there were no service interruptions. No explanation has been provided to explain why NB would say that the computers were down when they were not.

64. We record here that the One Plan system was comprehensive and had been used by healthcare providers with considerable success. Ms Corrigan has maintained her access to the system. It is apparent that the system was designed for the production of considerable amount of information on request, including matters such as wages.

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65. The evidence of Mr Devine was that he asked Ms Corrigan if there had been any safeguarding concerns and that she said there were none although she did refer to the need to attend a "care review with a social worker called Hannah". This, in fact, was a safeguarding strategy meeting regarding JC. The inspectors were subsequently informed of the true scope of the meeting by social services and attended the meeting. This refers, amongst other matters to approximately 17 missed calls in the last 10 weeks. In our view it is unlikely that Ms Corrigan was unaware that the meeting re JC that she had characterised as a care review concerned serious safeguarding issues.

Safeguarding Concerns Raised

66. The evidence before us shows that there were numerous safeguarding concerns which were recorded. Exhibit BD/48 shows the records made by a number of social workers [C853- 875] between 3 and 27 August 2017 in relation to about 15 service users. (Some of these record earlier issues with the same SU). In our view there is little reason to doubt that that the contents of the records are a reliable and conscientious account of the information provided to social services and, in some instances, the efforts of social workers to communicate with Ms Corrigan herself regarding the issues of concern. The makers of these records have not been called to give evidence. We have also not heard any direct/oral evidence from the SUs/family members. We attach weight to the records because we consider it unlikely that service users and/or their families would contact social services unless there were genuine matters of concern. In large part the information recorded relates to information provided when care which has been commissioned has not been provided. In many instances the information recorded shows that this is a repeated pattern of missed or late calls.

Some of the records also show the response, or lack of response, by Ms Corrigan when concerns were directly raised with her or with the office.

67. Overall, we consider that the sum of the safeguarding issues brought to our notice demonstrate an irresponsible attitude from the service provider, with complete disregard for the risk situations for the clients because of the provider's failures to deliver the service. The content of the notes we read collectively present with intense and continuing concerns. They indicate the sheer volume and frequency of shortfalls on the part of the Agency, and the range of significance of the consequences of these shortfalls in respect of the vulnerable clients, for whom care would not have been commissioned were it not necessary and appropriate in respect of their individual needs. We note that safeguarding issues included:

- missed visits by carers
- failure to report non-access calls/erratic timing of calls by carers, with consequences, e.g. irregular administration of medication, client confined to bed, client disturbed late at night and frightened medication missed, sometimes several doses
- lacks in communication between Agency and carers and family/friends
- Care plans incomplete/not followed/agreed changes not implemented
- poor cleanliness/insanitary issues not attended to by carers
- meals not prepared
- lack of response by Agency to safe guarding issues raised at strategy meetings.

68. In our view Miss Corrigan did not engage with the very real issues raised at the inspection in any meaningful way. Although providing information on some aspects she did not make herself available. She told Mr Devine that there had been no safeguarding issues when there very plainly had been in the immediate past. We do not accept her account that she was involved in training on 11 August 2017. Her attitude to inspection was to make a complaint about Mr Devine.

69. Ms Corrigan did provide an Action Plan in response to the Letter of intent which was deemed sufficient in terms of mitigation of risk on the basis that the LA would provide support/oversight.

70. In her witness statement Ms Walker said that she and Ms Roberts visited Your Care between 2 and 5 pm on 17 August 2017. Ms Walker stated that Ms Corrigan informed them that TA was to cover visits between 6.30am to 9.30 pm and her plan during her absence was for TA to deputise by coming into the office from 1pm to 4pm between shifts. Ms Walker's account is that she reminded Ms Corrigan how serious the situation was and that she should give serious consideration to cancelling her holiday, or that she at least needed to make

arrangements to have TA's shifts covered. Ms Corrigan agreed to cover TA's shifts but did not arrange it before she left. However, TA said she would arrange cover herself. Ms Walker's account is that she advised Ms Corrigan that although the Council has agreed to provide support it was not managing the service.

71. Despite the seriousness of the concerns raised Ms Corrigan went on holiday. Ms Walker and Ms Roberts attended Your Care between 10am and 3pm on Friday 18 August and between 10am and 2pm on 21 August 2017. TA said that she had never run an office before and that Ms Corrigan had told he that she would only need to check the rotas and arrange cover should a member of staff go off sick, and do some spot checks. TA also said that she had not been trained to complete rotas so NB, the administrative assistant, would have to change them on the system. Mrs Walker relates that on 17 August she observed that the staff were unable to identify missed calls due to the IT system being down. Amongst other matters the person to whom Ms Corrigan had delegated management [TA] was not, in the event, willing or able to take on the considerable responsibility involved. The administrative assistant [NB] knew how to operate the computer system but had no management experience. She ended up providing care in order to cover gaps in the rota but she was taken off calls because she did not have a current DBS certificate.

72. On 18 August 2017 another member of staff was found not to have a current DBS and so was taken off rota. Staff member AT had been put on the rota even though she had said she could not work. This left people waiting for calls whilst cover was arranged. Two safeguarding referrals came in. Mrs Walker and Ms Roberts identified two further missed calls.

73. Ms Walker's account was that in 21 August it was discovered that two further members of staff, AT and SF, did not have valid DBS certificates. They each said that Ms Corrigan had told them that the DBS from their previous company was valid.

74. We did not hear oral evidence from Ms Walker because she was ill so her evidence was not tested before us. Neither party requested an adjournment to enable her to attend on a future occasion. It was not suggested by Mr Butler that her evidence should be excluded on the basis that it would be unfair to receive it. It was not suggested by Ms Corrigan in her evidence that she had any specific challenge to the broad accuracy of Ms Walker's account. We attach weight to Ms Walker's account.

75. We find that missed calls continued in the period between the formulation of the Action Plan and the Magistrates' Court hearing of 22 August 2017. Although an alert had been set up on the system it was ineffective because there were insufficient staff on rota to cover the planned calls.

76. We consider that it was wholly unsurprising that by 21st August 2017 Wirral Council considered that they were no longer able to support the service that Ms Corrigan was purporting to provide given the problems that were experienced.

77. In her evidence Ms Challinor explained the reasons for the decisions reached at various stages. She explained that Mr Devine had alerted her to his significant concerns about the service and about the breaches of regulations 9 (person centred care), 11 (consent),12 (safe care and treatment), 13 (Safeguarding), 17 (Good Governance) 18 (Staffing) 19 ((Fit and Proper Persons employed). She explained that urgent action was not taken under section 30 on 16 August because: the LA had agreed to provide daily oversight and to ensure that no care visits to homes were missed; assurances had been given by Ms Corrigan about a number of improvements that had been made and that further improvements were being made; TA would be managing the service in her absence. She explained how matters progressed resulting in emails to and from Ms Corrigan on Friday 18 August. On 21st August following emails from Ms Roberts she and others formed the view that the current concerns were rated as “Extreme” in seriousness and that service users were at significant risk of harm. We found Ms Challinor to be a conscientious witness who gave her honest opinion as to the significance of risk on the basis of the material before her when the decision was made.

78. There is, of course, now more evidence to consider. In our view the attitude Ms Corrigan displayed in her oral evidence as to the risks to service users was defensive, combative and dismissive. She was unwilling to take any or any true responsibility for the services she had contracted to provide, and displayed a lack of any, or any real, understanding, of the concept of vulnerability in service users. One example of this was her view that some service users had family who could provide care themselves and so there was no risk. Taking HB as another example, when asked about the importance of the visits Ms Corrigan suggested in oral evidence that HB could feed herself. However, her care plan records that HB has little appetite, forgets to eat and struggles to cook for herself.

79. Having considered all of the evidence in the round, we find that the Appellant had in August 2017, and has now, little or no true insight into the risks posed by missed calls, late calls and short calls. The care plans were made and the level of care commissioned because the service users were assessed as needing that level of care in connection with critically important matters for vulnerable service users such as taking medicine as prescribed, eating and drinking regularly, being assisted with getting out of bed and with other mobility needs.

80. We find that in August 2017, and even before us, Ms Corrigan did not acknowledge the real problems with the service she was purporting to provide. Although she had provided an Action Plan her position before us was that there had never been any (or any real issue) missed calls or the many real concerns regarding the service she provided, but we do not accept her evidence. She demonstrated in her evidence that she was prepared to say that which suited her case, for example, by telling Mr Devine that there had been no safeguarding concerns and there had never been any missed calls.

81. In our view it was clear by 21st August 2017 that the Action Plan had not been effectively implemented because calls were still being missed and that the risks

were not capable of being mitigated by those left in charge by the Appellant. Even today Ms Corrigan does not have any real appreciation of what was likely to have been involved in turning the service around.

82. In our view the other breaches of the regulations are relevant in overall context because they illustrate that the missed calls were part and parcel of an organisation that was failing to adhere to basic requirements in key areas which is, in turn, relevant to the Appellant's capacity to effect all the changes necessary. We find that Ms Corrigan was (and is) unable to accept or meaningfully address the significant deficiencies in the provision of care by Your Care.

83. We have considered the submissions made regarding the seriousness or significance of the risks. Emphasis is placed on the absence of medical evidence to support the suggestion made in the evidence of Mr Adnams, in particular, as to the potential consequences of missed calls to the individual patients concerned. In our view this misses the whole point. The specific conditions of each individual patient are not the key consideration within the scope of a risk assessment under paragraph 30. The SUs cited were those in respect of whom missed calls were evidenced in the period before and following the Action Plan. If the pattern of missed calls had been permitted to continue, any of the clients among the 49 or so for whom Your care had contracted to provide services would, in all probability, have been subject to missed call(s). Which patients they might be, what medical conditions each had, and whether each, or any of them, had relatives ready and able to step into any gaps due to missed calls, was (and remains) unknown and unknowable. In our view it is simply not tenable to suggest that the issue of risk can only be assessed by reference to medical evidence as to cause and effect. The Appellant can, of course, point to the absence of any proven physical harm to those patients whose visits were missed and we take that into account. We are not, however, persuaded, that being satisfied as to the high threshold that unless registration is cancelled "it appears that there will be a serious risk to a person's life, health or well-being" involves waiting for actual harm to occur.

84. As set out above our consideration of the issues is made at today's date. It was open to Ms Corrigan to adduce evidence to demonstrate that the service she would provide today would not present serious risk to the life, health or well-being of service users. We have made our own assessment. The Respondent has satisfied us that the high threshold engaged in section 30 was, (and is still), met. It appears to us that there "will be a serious risk to a person's life, health or well-being" unless the registration is cancelled.

85. The fact that the high threshold for section 30 was (and is still) met does not mean that the power of cancellation should necessarily be exercised. We have a discretion which must be exercised in accordance with the principle of proportionality.

86. We address the Razgar issues for the avoidance of any doubt. The appellant's interests are part of her private life and the inference involved in the decision is plainly such as to merit the protection of her interests under the ECHR.

87. The Respondent has satisfied us that that the decision taken was in accordance with the law. We are also satisfied that the decision was objectively justified and necessary in order to protect the public interest in the protection of the safety and well-being of service users and the maintenance and promotion of public confidence in the system of regulation.

88. In reaching our decision on the issue of proportionality, we took into account that the impact of the cancellation was very serious indeed. The business that Ms Corrigan had developed was brought to an immediate end and the clients/service were transferred to other providers. Not only was the Appellant prevented from earning her living, with consequent impact upon her employees and the service users, the fact of cancellation had (and continues to have) a significant impact upon her reputation, and may well impact upon her future in the provision of health care services. There was also the impact on the service users themselves and their families, some of whom have since said that they were happy with the service provided by Your care.

89. We recognise that when assessing proportionality alternatives to the most serious response should be considered. The Appellant contends there were other options available such as the giving of a Warning Notice or Notice of Proposal under section 29, or suspension pending further investigation under section 31 of the Act on the grounds that the Respondent "has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm".

90. Our task is to confirm the decision or to state that it shall have no effect. We have considered the issues of justification and proportionality by reference to other measures available to the Respondent in the exercise of its regulatory powers. Given our findings as to Miss Corrigan's denial that missed calls occurred or her inability to accept or recognise that missed calls posed a serious risk to the life, health and well-being of SUs, we are not persuaded that a Warning Notice would have been adequate to address the serious risks that we have found existed. On the facts the pattern of carers failing to attend SU's continued despite the Letter of Intent and despite Ms Corrigan's Action Plan. Further, in order for any conditions/restrictions to be adequate to address the serious risk that existed any decision maker would have to be satisfied that Ms Corrigan could be trusted to engage with the Respondent in a transparent way and cooperate with the Inspection regime. In the light of our findings we have little or no confidence that she would do so and/or that conditions/restrictions would be realistic, effective, workable or practical. We are satisfied that the imposition of conditions/restrictions would not have been (and would not now be) effective in seeking to address the serious risks involved.

91. We considered whether suspension was a suitable alternative and thus whether the decision made was unnecessary, unjustified and disproportionate. The test for suspension involves a lower threshold in terms of risk. Although it can be said that the same protection would be afforded by suspension rather than cancellation, parliament has decided that where the test under section 30 is met

the appropriate response (i.e. that which is justified in terms of the public interest objective) is that of cancellation. Here we have found that there was, and remains, serious risk of harm to life, health or well-being.

92. We have balanced the impact of the decision upon the Appellant's interests against the public interest. We do not consider that Ms Corrigan had (or even now has) the ability or capacity to effect change within the time scale implicitly involved if cancellation were not to be confirmed. We consider that the facets of the public interest engaged outweigh the interests of the Appellant. In our view the decision to cancel registration was (and remains) reasonable, necessary and proportionate to the serious risk to life, health or well-being engaged.

Decision

The decision to cancel registration is confirmed and the appeal is dismissed.

Judge Siobhan Goodrich
Care Standards
First-tier Tribunal (Health Education and Social Care)
Date Issued: 22 December 2017