Care Standards

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

FIRST-TIER TRIBUNAL
HEALTH EDUCATION AND SOCIAL CARE CHAMBER
CARE STANDARDS

[2018] 3428.EA

Judge G K Sinclair
Specialist member C Joffe
Specialist member M Cann

Between :–

THE LIME TREES RESIDENTIAL CARE HOMES LTD *Appellant*

and

CARE QUALITY COMMISSION *Respondent*

DECISION

Before the tribunal sitting at the Royal Courts of Justice on 18th, 19th & 20th June 2019

Representation

For the appellant : Margaret Hodgson (counsel)
For the respondent : Alexander dos Santos (counsel)

The appeal

1. The appellant company is a provider of accommodation for persons who require nursing or personal care. By application dated 14th August 2018 it appeals against the notice of decision by the Care Quality Commission dated 18th July 2018 to cancel its registration as a service provider.

Background

2. The appellant company, the registered office of which is at 2 The Limes Avenue, New Southgate, Enfield, London N11 1RG, was incorporated on 19th April 1995 and was in its early days involved in the provision of residential care, but in recent years and until his unfortunate death in early October 2016 the business was being run personally by its principal director, Mr Aloysius Onyerindu. Since then his widow, Mrs Helen Frances Onyerindu, has been the company's sole director. She had assisted him in the running of the business, but as senior carer rather than as someone involved in management. Following her husband's death she employed Clement Ilesanmi Apejua to manage the business for her, but in time this was transferred to the company, which then applied to the CQC for registration. After the usual enquiries the company was registered on 5th March 2018 as a service provider of the following regulated activity: Accommodation for persons who require nursing or personal care at the address 2–4 The Limes Avenue, London N11 1RG.

3. On the same date Ugochinyere Diane Onyerindu (the deceased's daughter) became nominated individual and Clement Ilesanmi Apejua became registered manager.

4. From the outset the conditions imposed on the registered provider were that:
   1) The registered provider must ensure that the regulated activities are managed by an individual who is a registered manager in respect of each regulated activity at Lime Trees
   2) The registered provider must only accommodate a maximum of 20 service users at Lime Trees
   3) The registered provider must not provide nursing care under accommodation for persons who require nursing or personal care.

5. An unannounced inspection of the appellant took place on 13th, 15th & 19th March 2018, following which a notice of decision was issued on 23rd March 2018 to impose as a new condition on the appellant's registration that:

   > The registered person must not provide accommodation for persons who require nursing or personal care to any new service user at The Lime Trees Residential Care Home, 2–4 The Limes Avenue, London N11 1RG without the prior written agreement of the Care Quality Commission.

6. Following an appeal by the appellant that decision was upheld, the tribunal finding in its decision dated 4th May 2018[1] that there was reasonable cause to believe that unless the respondent acted any person will or may be exposed to risk of harm.

[1] *The Lime Trees Residential Care Home Ltd v CQC* [2018] 3311.EA-MoU

7. Following the inspection and imposition of a condition preventing the appellant from taking in any more residents save with the written permission of the CQC a number of London Boroughs removed the residents placed by them at the home, leaving only a single male resident who refused to leave. He has remained the sole resident ever since.

8. On 23rd April 2018 the respondent issued a Notice of Proposal under section 26 of the Health and Social Care Act 2008 to cancel the appellant's registration. The appellant objected and in May 2018 made written submissions, which were referred to and dealt with by a senior member of the respondent's staff in a department previously uninvolved in the inspection and decision-making. On 18th July 2018 that officer decided to adopt the proposal and formally issued a Notice of Decision to Cancel.

9. Following issue of the Notice of Proposal in April and the Notice of Decision in July, and the appeal launched in August 2018, two further inspections of the premises have taken place – each conducted by Ms McHugh as lead inspector:
   a. On 14th September 2018, when only one service user remained in residence
   b. On 30th April 2019, when the same service user was still the only resident.

10. Following the September inspection, and with a new registered manager in post, many of the breaches were seen to have been resolved, and the CQC agreed to a stay of the appeal until January 2019 to see if there could be further improvement. The appellant was encouraged to apply for permission to introduce more residents into the home. Its attitude, however, was that it was trapped by Catch 22: while the CQC remained set on cancellation of registration and the appeal had yet to be determined local authorities were not prepared to place new residents in the home for fear that upon cancellation they would quickly have to find alternative provision for them. However, without the introduction of new residents the appellant would be unable to satisfy the CQC that the improvements in standards now justified the rescission of its decision to cancel the appellant's registration.

Material legal provisions

11. The relevant statutory provisions are to be found in the Health and Social Care Act 2008. The first Part of the Act deals with the establishment and role of the Care Quality Commission as regulator. This is divided into a number of Chapters and, in Chapter 2, section 8 defines "Regulated activity" as follows:
   (1) In this Part "regulated activity" means an activity of a prescribed kind.
   (2) An activity may be prescribed for the purposes of subsection (1) only if–
      (a) the activity involves, or is connected with, the provision of health or social care in, or in relation to, England, and
      (b) the activity does not involve the carrying on of any establishment or agency, within the meaning of the Care Standards Act 2000 (c.14), for which Her Majesty's Chief Inspector of Education, Children's Services and Skills is the registration authority under that Act.
   (3) For the purposes of subsection (2), activities connected with the

provision of health or social care include, in particular–

(a) the supply of staff who are to provide such care;

(b) the provision of transport or accommodation for those who require such care;

(c) the provision of advice in respect of such care.

12. Section 9, which defines both "health care" and "social care", explains the latter in sub-section (3):

> "Social care" includes all forms of personal care and other practical assistance provided for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance.

13. By section 10 any person who carries on a regulated activity without being registered under Chapter 2 of the Act in respect of the carrying on of that activity is guilty of an offence, and section 11 provides that a person seeking to be registered as a service provider must make an application to the Commission (the CQC).

14. Also pertinent in the instant case is section 13, which provides that:

(1) The registration under this Chapter of a person ("S") as a service provider in respect of a regulated activity must in prescribed cases be subject to a registered manager condition.

(2) In deciding whether to impose a registered manager condition under section 12(3) or (5), in a case where subsection (1) does not require such a condition to be imposed, the Commission must have regard to prescribed matters.

(3) For the purposes of this Chapter, a registered manager condition is a condition that the activity as carried on by S, or the activity as carried on by S at or from particular premises, must be managed by an individual who is registered under this Chapter as a manager in respect of the activity, or the activity as carried on at or from those premises.

15. Cancellation of registration is dealt with by section 17:

(1) The Commission may at any time cancel the registration of a person ("R") under this Chapter as a service provider or manager in respect of a regulated activity–

(a) on the ground that R has been convicted of, or admitted, a relevant offence;

(b) on the ground that any other person has been convicted of any relevant offence in relation to the regulated activity;

(c) on the ground that the regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements;

(d) on the ground that R has failed to comply with a requirement imposed by or under Chapter 6;

(e) on any ground specified by regulations.

(...)

(4) In this section "relevant requirements" means–

(a) any requirements or conditions imposed by or under this Chapter, and
(b) the requirements of any other enactment which appears to the Commission to be relevant.

16. If considering cancellation the CQC must comply with the procedural steps set out in sections 26 to 28, namely the service first of a notice of its proposal to cancel (s.26). The notice must inform the recipient of the right, within 28 days of service, to make written representations about any matter which that person wishes to dispute (s.27), during which time the CQC must not determine the matter. When it does so, taking into consideration any representations made, if it decides to adopt a proposal of which it was required to give notice under section 26 it must give notice in writing of its decision to any person to whom it was required by section 26 to give notice of the proposal. The notice must also inform the recipient of the right of appeal to this tribunal under section 32 (s.28).

17. By section 32(3), on an appeal against a decision of the CQC, other than one to which a notice under section 31 relates, the tribunal may confirm the decision or direct that it is not to have effect.

18. In seeking to cancel the appellant's registration the respondent has sought to rely upon a number of regulatory breaches found at the first and/or second and third inspections. These can be found in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[2], of which the respondent alleged breaches of the following regulations – listed in numerical order rather than by severity of breach:

a.	Reg 9	Person centred care
b.	Reg 10	Dignity and Respect
c.	Reg 11	Need for consent
d.	Reg 12	Safe care and treatment
e.	Reg 13	Safeguarding service users from abuse and improper treatment
f.	Reg 15	Premises and equipment
g.	Reg 16	Complaints
h.	Reg 17	Good governance
i.	Reg 18	Staffing, and
j.	Reg 19	Fit and proper persons employed.

Grounds of appeal

19. The appeal application form, at [A4], lists the following seven grounds of appeal:
1) The respondent's decision made on 18th July 2018 to cancel the Applicant's Registration is not borne out of the evidence of the conditions operating at the home as of the date of decision.

2) The decision to cancel the applicant's registration is unreasonable in that it was made without a fact finding visit by the respondent to confirm if the applicant has implemented the plans set out in its Action Plan submitted to the respondent following receipt of the Notice of Proposal dated 23rd

[2]SI 2014/2936

April 2018.

3) The decision to cancel the applicant's registration was made in error in that it was based on inspection reports which had been superseded by Improvement Plans implemented by the applicant. There was therefore no lawful basis to cancel the appellant's registration on 18th July 2018.

4) The decision to cancel the applicant's registration is inappropriate, arbitrary, unilateral and prejudicial to the best interests of the service user, the user community and the effect on the applicant's business.

5) The applicant requests that the appeal be allowed, its registration restored and the condition imposed by the respondent against the applicant's registration be removed.

6) The applicant has taken steps to ensure that the regulated activity at the home is being carried out in accordance with the requirements of the Health and Social Care Act 2008, that there is continuing provision of care which protects people's health and well-being, that the service provided by the applicant meets the fundamental standards to ensure people receive safe, effective, caring, responsive and well led care at the home.

7) The respondent's decision to cancel the applicant's registration is therefore wrong in law and in fact.

Hearing and evidence

20. The tribunal was presented with one over-stuffed lever arch file comprising 1 000 pages. In addition a 45 page Scott Schedule was produced, detailing every allegation. As the appellant company's responses to allegations in this schedule tended to deny the entirety of an allegation even if only part had been disputed by a staff member, this document was of limited assistance in identifying the real issues in dispute. Counsel also produced skeleton arguments setting out their clients' respective positions.

21. The tribunal was later provided with an amended Scott Schedule (with each allegation individually numbered), a copy of the draft and final Inspection Report of the inspection carried out on 30th April 2019 (published on 17th June 2019 – just before the appeal), the completed Factual Accuracy Check form responding to challenges to the draft report, and a copy of the decision in the earlier appeal against the imposition of a new condition.

22. The CQC, as respondent, opened the appeal and relied upon the written statements and oral evidence of:
    a. Orla McHugh, Lead Inspector – three statements dated 4th March 2019 (which amongst its voluminous exhibits included her original 135 paragraph statement dated 1st May 2018 made for the earlier appeal against imposition of a condition), 22nd March 2019 (dealing with the September inspection), and finally 2nd May 2019 (which dealt with the April 2019 inspection)

b. Martin Haines, Inspection Manager – one statement dated 21st March 2019
c. Alison Murray, Head of Inspection for Adult Social Care (London region) – one statement dated 25th February 2019.

23. The appellant relied upon the written statements and oral evidence of:
a. Ugochinyere Diane Onyerindu, nominated individual – three statements dated 8th March 2019, 22nd March 2019, and (in response to McHugh's statement dated 2nd May 2019) 16th May 2019
b. Job Enyinda, current registered manager – one statement dated 16th May 2019.

24. Although she was present throughout the proceedings the tribunal was surprised that the sole director and shareholder in the appellant company, Ms Onyerindu's mother (who prior to her husband's death in late 2016 had played a significant caring role at the home), submitted no evidence and remained entirely silent.

25. Confirming the content of her various witness statements, Ms McHugh stated that her inspection in March 2018 revealed a situation worse than she had ever previously encountered. The findings are set out quite methodically in the Notice of Proposal, at [B1–17], but amongst her principal concerns were:
a. Finding a number of residents left in their rooms with soiled incontinence pads, urine-soaked mattresses, and a fresh pillowcase being put on a still-wet pillow
b. A strong smell of urine and, in some cases, faeces on the premises
c. Failure to assess the risk and prevent the spread of infection by keeping the place clean
d. Insufficient response to a request by one resident for the supply of pull-up pants
e. Insufficient medical response to a resident's complaint that a wardrobe had fallen on her, causing severe but unrecorded bruising to her upper arm; with no attempt to obtain medical attention for her for over a week (after the incident was reported on inspection), and despite an instruction from the local authority to take her to A&E
f. Delay in the inspection and securing of other wardrobes so that they could not topple over
g. Failure to prevent abusive and degrading treatment, e.g. by addressing service users in a brusque and undignified fashion
h. Use of a walk-in shower that, when the door was left open in order for staff to assist when required, exposed naked occupants to view by other residents even as far away as the lounge, despite the presence of a flimsy shower curtain in the corridor
i. Failure to keep records of assessments of capacity to assess if residents had capacity to consent to their care
j. Failure in some cases to make a DoLS application to the local authority, with the consequence that some residents were being unlawfully detained
k. Delay in the preparation of care plans
l. Failure to maintain adequate staff recruitment and training records

m. Deployment of insufficient staff
n. Failure to maintain accurate records of the administration of prescription drugs
o. Failure adequately to assess and mitigate risk, e.g. by failing to keep personal emergency evacuation plans (PEEPs) in the grab bag instead of service users' files – where they should not have been
p. Lack of oversight, despite the registered manager having been de facto in place since June 2017.

26. Cross-examination on behalf of the appellant began by challenges to Ms McHugh about whether the decision to impose a further condition on the registration, and later to issue a Notice of Proposal to cancel registration, had been reached improperly – without waiting for proper Management Review Meetings. This was denied, and details provided of meetings convened on various dates.

27. It was put to her that she had overstepped her authority by informing local authorities such as Enfield of the CQC's intention to cancel the registration even during the March inspection. This was denied. She had exchanged factual information and urgent safety concerns with officers from Enfield, who had themselves visited the day before the CQC inspection and had specific safeguarding concerns. As a result the decision was taken to begin the second day's inspection at 04:00, visiting during the night shift to see the state of residents in their rooms. Wet beds, soiled incontinence pads and unheated rooms were thus observed first hand.

28. When it was put to her Ms McHugh accepted that, with so many breaches observed, the service would require at least a year to eighteen months to make improvements and turn it around. When asked by the tribunal whether, in such circumstances, the respondent might not have adopted some other approach than moving straight for cancellation (e.g the imposition of further conditions) she replied that the team would have followed the risk process set out in the enforcement decision tree.

29. After being questioned about the wardrobe incident, and the lack of medical attention received by the time of the inspection – 5 days later – she repeated that the resident was very forthcoming about it during the inspection, told the team that she had received no medical attention, and volunteered to show them her injury. Ms McHugh repeated her view that before the inspection had even commenced the service user's injury, a bruise covering much of her upper arm, should have received a medical professional's attention.

30. Turning to the issue of the shower, Ms McHugh agreed that by the time of the second inspection in September both it and the premises generally were a lot cleaner; but she did not agree that the concerns about the shower were settled. It was just a shower, placed on a corridor. While the curtain had been replaced she could not see how that shower was fit for purpose, especially if service users need assistance to have a shower. A shower curtain can easily be pulled aside – as happened when she was there. Another resident pulled it aside and looked in. Ms McHugh saw from the lounge a person naked in the shower, and

simply did not understand why it is still in use.

31. It was put to her that, with only one resident on the premises who did not require any assistance and was thus content with the shower, it might be considered an imposition to spend a substantial sum on providing alternative shower facilities if the home were still under threat of cancellation of registration.

32. Discussion then turned to the issue of introducing new service users, which an early email between Mr Haines and the appellant [C334] referred to consent being granted only in exceptional circumstances. This had been soon after the March inspection that had revealed a service operating significantly short of expectations, and when it was still seen as high risk. By September that had changed, but with only one resident it was not possible to judge whether this level of care would be both scaleable and sustainable if numbers increased; especially if some new service users, through infirmity, dementia or otherwise, imposed greater demands upon the appellant and its resources. A stay of the appeal proceedings was therefore agreed, and the CQC would look more favourably to requests for consent to the introduction of more service users so that the appellant's abilities (especially with a new registered manager in post) could better be assessed.

33. Nevertheless, there remained issues about the appellant's management systems and, even though not in use, some soiled mattresses were still found in residents' rooms. By the time of the April 2019 inspection there was still only one resident, who was content with his circumstances, but there remained problems with management systems such as the recording of staff references and training. A specific example concerned staff training in the administration of medicines in various ways. There was only one resident, and his medical needs were not great. Despite that, staff were marked as having been observed administering medicine in ways that the single service user simply did not require. When challenged, the registered manager responded that on the basis of previous employment experience he had accepted that those staff members would have known what to do. He had not observed their abilities personally.

34. On staff records more generally, there was some confusion about particular records that, for the purposes of the hearing bundle, had been redacted. After a short break the parties were able to agree that some exhibited documents were incorrectly labelled. It was put to Ms McHugh, and she was obliged to concede upon closer examination of the documents, that certain other findings she had made concerning service users' records (and the alleged failure properly to assess risks in residents' care plans, etc) were wrong. A user she had recorded as requiring a catheter (and thus staff needed training in its use) did not in fact have one in place upon admission. It had been removed or come off while in hospital.

35. Despite the use of industry standard management audit templates she was not confident that the appellant was able to apply them properly to the actual service involved. There was an audit report prepared in February 2018, yet it had failed to identify the numerous serious regulatory breaches discovered

during the inspection one month later.

36. Overall, despite a change in registered manager and resolution of many of the breaches identified in March 2018, the situation now – with only one resident and a reduced staff – still did not inspire confidence. In March 2018 many service users had dementia, or had mental health issues, continence issues, and/or a need for help with dressing and washing. The appellant had to cope with more care needs than at present. By the end of the third and final inspection she was not satisfied that the appellant could deal with a scaling up to handle more complex needs on a sustainable basis.

37. Mr Haines, Ms McHugh's line manager, was questioned about contact with local placing authorities, about his willingness to agree to new admissions – as he was aware of another provider in his area which was subject to a similar condition and able to work with it, his expectations of the nominated individual as a point of contact with the organisation, and his awareness of the "Good" rating achieved by the home when her father was in charge in 2016.

38. Alison Murray, Head of Inspection, was also questioned about the decision tree process. While it was great to see the improvements made in September 2018, that did not negate the serious breaches found in March 2018. She had to consider whether the decision to cancel was still proportionate. Her decision was that there was only one service user, whose needs were atypical, so it was appropriate to continue with cancellation – but to keep it under active review. She confirmed that she was the person who had agreed to a stay of proceedings while the opportunity was provided to admit new residents in order to demonstrate the care that could be provided. Ultimately, it was her decision that the improvements made by September 2018 with just one service user could not be scaled up or sustained.

39. In re-examination it was put to her that the appellant's counsel had suggested that since all the concerns were identified in March there had been significant changes, eg a different registered manager, and such a significant change that it should affect the decision to cancel registration. Her response was to say that there is a lot of continuity between the previous registered people and the current registered provider. Its obligation is to meet the regulations and fundamental standards, as people have a right to expect decent care. That should apply from day one. People should not be put at risk through using the service.

40. On the subject of the shower, while she had not personally visited the premises she would have expected the registered provider or registered manager to take more robust measures to ensure that service users' privacy and dignity was not compromised. This could include taking the shower out of use, requiring them to use another bathroom, etc.

41. Ms Onyerindu, the nominated individual since 5th March 2018, gave evidence. She began by drawing the tribunal's attention to certain documents on service users' files which showed that Ms McHugh had drawn mistaken conclusions on certain matters, such as a failure to record in the care plan that one resident

was admitted wearing a catheter, and ensuring that staff members were trained in dealing with it. In fact the hospital discharge letter confirmed that the catheter was no longer in use. In another case medical records did not show that a resident was admitted with a grade 1 pressure sore or ulcer.

42. She confirmed that, following a CQC interview, she was appointed as nominated individual in early March 2018, following which she and her mother went off on holiday – returning on 13th February to learn that an inspection was in progress. Prior to that, and while at university, she had been involved with the home but not with auditing. In July 2017 she joined in an admin capacity. She liaised with the person appointed in March 2018 as registered manager, but who had been appointed by her mother to run the home in mid-2017 – some months after her father's death. Both answered to her mother.

43. Before then she was an analyst with Deloittes. On her father's death in October 2016 she and her mother were taking steps to change the registration of the business. They then took steps to register the business as a company, during which she was liaising with the CQC registration inspector. They decided to register under the company route, so required a nominated individual. From her research the nominated individual was liaison and key point of contact, so on registration she became that nominated individual. She confirmed that the limited company had "always been there" and so had been used for the purpose of registering the service with the CQC.

44. Cross-examined, she explained that the freehold of the premises is owned by her mother personally. Her father had operated and been registered as sole provider for a number of years. Her mother was the senior carer. After his death in 2016 she continued to run and own the home, later with her daughter's help. Mother is sole company director.

45. She confirmed that the original certificate of registration [C82–83] was wrong to refer to her mother as nominated individual, but this had been corrected on the CQC's website.

46. Confirming her awareness that a registered provider had to comply with the regulations, she agreed that she had held a managerial role since late 2017, but that only a nominated individual has the authority to do an audit, and until March 2018 that had not been her responsibility.

47. Taken to the various items in the Scott Schedule, she accepted under item 2 that a full care plan had not been completed for service user M but went on to say that it depends when a full care plan should be created. It could be 48 hours, but under regulation 9 it has to be robust so depends on when one can meet family members and other persons.

48. When challenged that in this specific instance a full care plan was not in place for a month and ten days, she responded that while a full care plan is being written a temporary care plan would be in place. A temporary care plan is an interim care plan, based on the pre-admission assessment. This would be kept on file with the service user's name.

49. On the catheter issue, she accepted that if someone has had a catheter there is some risk that they may need to have one inserted, that there may come a time when someone may need one, and so the staff need to know how to manage.

50. On the various observations of incontinence, wet mattresses, etc she accepted what had been observed; she had not seen it herself and had relied on what staff or service users had told her directly. She believed that staff members had fulfilled their duties at all times.

51. On the wardrobe/bruising incident she said that she had not been aware of it. She went away on 4th March and came back on 13th March. On the significance of the bruising, she could only go on what she was told. The registered manager told her that his assessment was that it was minor. He did take steps to contact two GP surgeries (which refused to get involved), the district nurse and CHAT[3], and finally take the service user to a walk-in clinic, but she had declined. He had not taken her to A&E, as directed in an email from Enfield to the home on 15th March which she had not seen at the time, and would have gone to the registered manager. She accepted that all service users are vulnerable, that this was also a safeguarding issue, and that there should have been a safeguarding referral. By 13th March there had been no safeguarding referral.

52. It was put to her that she must have been beside herself when she read the inspection report, and must surely have decided to investigate every single problem. She confirmed that she did.

53. On the issue of incorrect completion of the MAR chart, she was not there on the day of inspection and so had to rely on what the registered manager had told her.

54. In relation to item 25 in the Scott Schedule, service user E had cognitive impairment and complicated needs not dealt with properly in the care plan. The appellant's response recorded against this item was "Not accepted". This was wrong and "Not" should be deleted. Asked what was the purpose of the registered manager having an interim care plan which is not documented, she said she thought that what she was trying to say here was that although the risk was not in the interim care plan it was orally presented to the staff. When it was put to her that this would pose a safeguarding issue, and a serious breach of the regulations she answered "Yes." At the moment there would be no such verbal indications and all would be documented.

55. It was put to her that the PEEP forms were not kept where they should be kept. She replied that she thought that what the inspector was saying was that there were PEEP forms for all but one service user, and the registered manager had kept it in another place. They should all be in the grab bag. Put to her that residents had been put at risk because these documents were not accessible,

[3]The local Care Homes Action Team

she accepted that they were not where they should be.

56. On the issue of the shower, she said that it is designed so one can close the door. Every time it as used by a service user the fan was working. She never saw incidents of a staff member showering a person with the door open, and in the corridor there is a shower curtain. There is a door to the main living room, but she agreed that the door has glass in it. It was put to her that a person could be seen in the shower, from floor level, and conversations could be overheard. She accepted that that was Ms McHugh's observation.

57. She was also questioned about DoLS records in the files, and accepted that even if a Power of Attorney was on file that was insufficient and DoLS should have been applied for. On the audit toolkit she thought it was good, but it did depend on the person checking. She also accepted that in March 2018 there were deficiencies with staff folders, DBS certificates, and issues with how staff had been recruited.

58. On the complaint that there were insufficient staff she said that when she went on holiday there were only fourteen service users. When she came back there were three new ones. The appellant had no designated cleaner or cook, as it had not recruited yet. There were three members of staff, plus the registered manager, making four. She agreed that if, prior to leaving, she had been told there would be three more, she would have said wait until we have employed new staff – a cleaner and a cook. She said that her mum is a trained chef, so if she was in she would do the cooking.

59. By the September inspection a new manager was in post and there had been considerable improvement, although with only one service user. She had not noticed the odour of urine from some spare mattresses, touched the wall in one room but did not regard it as damp (or that there was a leak), and disputed photographs of the cooker and extractor – stating that they were each used and cleaned daily. However, both oven and extractor had since been replaced.

60. She accepted that prior to recruitment good practice is to get references from previous employers. However, the staff members in question did have a good character reference on file. They all came from Seven Sisters, which is a training company that does not provide services. She was then referred to [D210], a Seven sisters letter dated 18/11/16, which referred to the applicant as being "one of our care staff". She was asked whether, knowing the nature of the organisation, this did not raise alarm bells?

61. By the April 2019 inspection some staff recruitment issues remained, with some character references undated, and on training the records showed observed competency in means of administering drugs that simply were not required by the sole resident. How then could they have been observed? They had not, with the registered manager admitting that he had assumed from their previous work experience that they would have known what to do. Finally, despite it falling due for renewal in February 2019, the appellant was seemingly willing to put up with delays by its regulator gas contractor so that, by the date of inspection in April 2019 the compulsory gas safety check had still not been

undertaken.

62. In re-examination Ms Onyerindu explained how she understood the responsibilities of her role as nominated individual, how she has a good working relationship with the new registered manager – whom she had recruited, and she checks what he is doing. Her mother's role is just as company director, but she answers to her. As her mother also has a lot of experience of care she would seek her views, but on a more professional basis the appellant has consulted SRG, a homes consultancy. She had spoken with them and wanted to find out about staff recruitment. SRG would be willing to review applicants' files before they were employed, and even be involved with interviews and audits if desired.

63. Mr Job Enyinda is the current registered manager. He took up office in September 2018, has a diploma in health and social care management, and has been working in the care industry for seven to eight years, from care assistant to manager level. He was senior carer, then team leader, then deputy manager. He worked for Four Seasons as senior carer and team leader, over a five year period. He became a deputy manager in HC1 Co, in Luton, for a year. When he left there, due to the distance involved, he got a job in London – that was a career progression job with Circa Care – in a residential home. He was there for seven months but left because of bereavement, as his father died and he had to go to Africa for the funeral. That took two months, so when he returned he worked in private business.

64. Asked about the allegedly deficient staff files, he said that he had taken action about these. He phoned the reference agencies to supply new references. Most of the gaps were now completed. The delay was in getting third parties to respond.

65. Cross-examined, Mr Enyinda said that when he applied for his current position he had not been told of the appellant's inspection history. He started on 3rd September 2018. He had a chance to read through previous inspection reports but at the time of employment was not aware of the condition imposed on new admissions. He explained that his understanding of the respective roles was that the nominated individual is supposed to be watching over what the registered manager is doing, with both working towards one goal – to make the home succeed.

66. He said that it was only at the meeting with Ms McHughes and Mr Haines that he was told that he could take in new residents (with consent). He had, however, been aware of the ongoing appeal against cancellation of the service. He was also aware of issues about staff and recruitment, and health & safety checks.

67. It was put to him that ensuring that a gas safety certificate is in place is an issue of safety, and a legal requirement. By the time of the inspection at the end of April there still had not been a gas check. He replied that he had noticed this and spoke to the nominated individual, and she said she had booked it, but the

person had no time to do it. He agreed that it should have been secured before the end of February. The gas check was booked, but the engineer was not available within the time frame. It was his responsibility to ensure that it was checked and noted. He wished he had done so. He then informed the nominated individual, who told him it had been booked. The engineer used by the home, had been used by it long before Mr Enyinda was employed. He did not accept it; and gave advice that this had to be sorted. It was in February when he raised it, and he tried to arrange for a fresh certificate.

68. He was then asked about staff references, and agreed that after chasing referees by phone he had added the dates on which undated references had been given. However, he had to agree that on the documents at [D233–234] the dates at the bottom right hand corner were 7th May 2019 – after the inspection on 30th April. They could not therefore have been on file during the inspection.

69. He was then asked about the medications competency checks, and the answer reported by Ms McHugh at [C518, para 38] and his explanation given in his statement at [D224, para 19]. Both referred to him ticking the boxes because he believed that, from previous employment experience, the staff concerned would have known the relevant medication pathways. In the witness box he blurted out that this was a mistake. The medications that were not in use had been ticked by him in error. Asked why he had answered Ms McHugh as he had, he said that when asked that question he was not in the right frame of mind – out of the pressure of the moment. The following rather flustered exchange then ensued:
Q – Is it important if, as a manager, you make an error – that you admit that?
A – I don't like being put on the spot.
Q – If not under pressure, why not correct it?
A – I did. I am correcting it.

70. Later, when asked about his previous experience of being inspected, he said that in homes in which he had worked previously some had inspection findings of Good. That would be at Circa Care and the previous one before. That is where he was manager, but he was not inspected while he was the manager. However, he did have experience of being inspected when he was a deputy manager, when he was more involved in the medication side in a 42 bed unit.

71. Questioned by the tribunal about his power to introduce change, Mr Enyinda confirmed that he had to consult the nominated individual for a budget. He did not have a budget that he controlled but had to ask for everything. In turn, she had to consult her mother, the director and shareholder of the company.

72. In his closing submissions on behalf of the respondent Mr dos Santos emphasised a number of points from the evidence, and drew attention to the lengthy Scott Schedule and the appellant's unhelpful answers. In that document very few incidents are admitted. One would have expected some acknowledgment of shortcomings, e.g. concerning the mattresses – not one but four. The answers are what she was told by staff members, yet despite them being failings for which staff members were responsible there were neither

investigations nor disciplinary proceedings. The registered manager was still in place until August 2018, with no explanation why.

73. Where, Mr dos Santos asked, is there evidence to show that despite making mistakes again and again, they can take further service users? That is why the decision taken to cancel is just as reasonable and proportionate now, where the service has been given every opportunity to improve. In those things that they can demonstrate they still fall woefully short.

74. Ms Hodgson began by saying that in 2016 the service as rated as Good, but following the death of the proprietor shortly thereafter, and registering on 5th March 2018, it was only weeks after that when the first inspection took place. There was turmoil at the home and the nominated individual had only just taken over. She stressed that Ms Onyerindu does not deny what was observed on inspection then, and she has admitted the appellant's failings.

75. However, she then said that when considering whether decisions are appropriate one should take account of the decision-making process, which is guided by the enforcement decision-making tree. At [C396], in Stage 1, the penultimate paragraph includes this:

> The MRM also ensures that there is a documented rationale for all decisions, therefore helping us to operate a clear decision-making process and to provide an audit trail to show how decisions were reached.

76. She continued by submitting that the tribunal had also heard from Mrs Murray that this is an ongoing process. A process which does not follow published guidance can be said to be irrational, and therefore the decision should be questioned.

77. Ms Hodgson said that the CQC has shown intransigence, especially about the shower. It cannot expect the home, which does not know its future, to spend what might be a considerable amount, to change the shower room. It was also intransigent to say that an audit process which follows its recommended toolkit – even if carried out properly – is insufficient because it is not service user oriented.

78. In relation to the nominated individual, it was said against her that she was too ready to take the view of the previous registered manager rather than investigate herself. This was partly accepted. She felt unable until registered as nominated individual. Until then she had no power. It had been foolish to trust the previous registered manager. The new manager and nominated individual understand their roles, and what needs to be done to meet targets.

79. Finally, she submitted that, despite recent breaches of a minor nature very different to those found in March 2018, with the right conditions the correct solution is not to uphold the decision to cancel registration. Asked what conditions were proposed, after some thought (and insistence that this really was a matter for the tribunal), she proposed that the following may be suitable:
    a. No new service user to be admitted until the shower is changed

b. That staff records (i.e applicants' records) are reviewed by a consultant
c. Regulating the number of service users that can be taken on, at whatever rate the tribunal thinks appropriate.

Discussion

80. As a preliminary point of law, the tribunal is satisfied that in considering the results of its March 2018 inspection, deciding on the need urgently to impose an additional condition on the appellant's registration[4], deciding to serve a Notice of Proposal, considering the appellant's responses to that through an officer not previously involved, and ultimately in deciding to issue a Notice of decision to cancel registration the enforcement decision-making tree was followed scrupulously by the CQC. The conduct of that initial decision-making cannot be faulted procedurally. While the CQC is keen to ensure that salvable providers are given a second chance this tribunal is not convinced, and no authority was cited by Ms Hodgson to the effect, that throughout the period before the appeal can be heard the CQC (which may continue to conduct inspections) is under a duty to go back to square one and follow the decision-making tree through to reach an entirely new decision. It has done enough, including by agreeing a stay of the proceedings for three months from October 2018. Its procedure cannot be challenged.

81. The tribunal carefully considered all of the evidence, both documentary and oral. It made a point of recognising that giving oral evidence – especially for lay people unfamiliar with courts or tribunals – can be a daunting process and that witnesses can become flustered, have difficulty in thinking on their feet and misspeak. The case would be decided on the totality of the evidence; not just on what was said in the witness box.

82. That said, the tribunal is concerned by and in reaching its decision places weight upon the following points:
    a. Subject to several minor errors about the content of some admission files in Ms McHugh's report – which fed into the reasons cited in the Notice of Proposal – the significant and extensive breaches found upon inspection in March 2018 are agreed
    b. There remains a lack of clarity about mother's role, and why no action has been taken or evidence provided by her to best protect the interests of the appellant company of which she is sole shareholder and director
    c. No disciplinary action was taken by the nominated individual or director (as the employer) against staff or the then registered manger, who remained in post until the end of August 2018
    d. The nominated individual is reasonable, and has obtained the right qualifications or taken the appropriate courses, but she is lacking in experience and insight and no evidence was produced showing that her experience of running care homes extends any further than the family business
    e. Perhaps due to her youth she has no leadership ability, i.e. to take control and manage staff
    f. The nominated individual displayed a distinct lack of openness about the

[4]Upheld by the tribunal in an earlier decision in May 2018

status of the company before and during Mr Enyinda's interview

g. The current registered manager was unimpressive, especially in his evidence (and the tribunal prefers his original explanation contained in his witness statement) about completion of the staff medication competency forms. The fact that he was inspected by the CQC when employed as a deputy manager with responsibilities for administration of medication tends only to demonstrate a lack of awareness of the need to ensure – and be able to prove – staff's knowledge of all required medication pathways

h. The service improvement plan produced is not an impressive document.

83. The tribunal's primary responsibility is to protect service users. This is a provider that appears to have been rudderless since Ms Onyerindu's father died. Perhaps for cultural or other reasons the deceased's widow employed a manager who then insisted that he was in control, and whom they were unable to supervise. Despite already being in charge and later being appointed as its registered manager on 5th March 2018 the home was found, within weeks, to be in breach of multiple regulations. Before he left the worst of these were resolved, but persistent issues remain about staff records and training. Should there be a serious incident involving a service user then it would not help the provider if, during any subsequent investigation, it were unable to demonstrate that it had taken proper care when recruiting staff, or in ensuring that they were trained and knowledge kept regularly up to date. Its insurers, let alone the CQC or prosecuting authorities, would expect no less.

84. In the circumstances, were proceedings to be stayed for a further six months it would not in this tribunal's determination help. Nor would the imposition of conditions. The first (concerning non-admission of any new service users until the shower issue is sorted satisfactorily) might be acceptable, but the other two are not. A third party cannot be bound by order to continue to provide consultancy services and to vet applicants' files. Can the tribunal impose a minimum quality threshold to such a consultant? As to the rate at which new admissions could be made, the tribunal asked Ms Hodgson what evidence was before the tribunal that would enable it to make an appropriate determination? The CQC is best placed to issue guidance or impose conditions on that issue, if so minded.

85. However, the CQC remains of the view that despite the appellant's efforts to improve, it can have no confidence that the care currently provided to one atypical but loyal resident can be scaled up to include a larger number of service users, many of whom are likely to have more complex needs. Nor does it believe on the evidence gathered so far that any improvement would be sustainable.

86. With some regret, for the tribunal does not discount that with greater experience learnt in other larger establishments Ms Onyerindu could not have a responsible and successful future in care provision, it must concur with the CQC and find that the present set-up is unsatisfactory and the decision to cancel the appellant's registration should be upheld.

FOR THE ABOVE REASONS IT IS DETERMINED THAT:

The appeal be dismissed and the Care Quality Commission's notice of its decision to cancel the appellant's registration as a care provider dated 18th July 2018 be confirmed

Dated 9th July 2019

Graham Sinclair
First-tier Tribunal Judge