Care Standards

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

The Tribunal hearing on 17, 18 and 19 February 2020 at the Royal Courts of Justice.

BEFORE
Ms. Melanie Lewis (Tribunal Judge)
Ms. Denise Forshaw (Specialist Member)
Ms. Heather Reid (Specialist Member)

BETWEEN:

Miss Esther Udoh (1)
100% Care Services Ltd (2)

Appellants

v

Care Quality Commission

Respondent

[2019] 3782. EA

DECISION

Representation

The Appellant was represented by Dr. O'Shea Counsel instructed by Graceland Solicitors.
The Respondent was represented by Mr. Saigal Solicitor Advocate instructed by the Care Quality Commission

Witnesses:

We considered statements from the following witnesses:

Respondent:

1. Darren Boakes: Inspector CQC + second witness statement
2. Margaret Lynes Inspection Manager
3. Alison Murray Head of Inspection for Adult Social Care. London region.

(read).

Appellant:

4. Esther Udoh+ second witness statement
5. Chucks Okah Care Worker (read).

Reporting order

1. There shall be a Restricted Reporting Order under Rule 14(1)(b) of the Tribunal Procedure Rules (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 ('the 2008 Rules') prohibiting the publication (including by electronic means) in a written publication available to the public, or the inclusion in a relevant programme for reception in England and Wales, of any matter likely to lead members of the public to identify any service user or their family member mentioned in the appeal.

The Appeal

2. The appeal by Miss Esther Udoh on behalf of 100% Care Services Ltd on 5 August 2019 has been clarified to be in respect of the decision of the Care Quality Commission dated 12 July 2019 to cancel the Appellants registration as a service provider and registered manager in respect of the regulated activity, namely personal care from the location of 100% Care Services Ltd, 23 St John's Road, Canning Town, London E16 INS.

3. What decision the appeal was against, was not straightforward. The solicitor on the record as acting for the Appellant, had ticked the wrong box on the appeal form. She was out of time to appeal the urgent notice of decision dated 7 June 2019 to restrict new clients without prior permission of CQC.

4. The Tribunal issued the appeal on the basis of the copy of the notice of decision provided with the appeal notice, which related to the cancellation of the Appellant as a registered provider. She had not provided the notice cancelling her registration as the registered manager.

5. At the commencement of the hearing Dr. O'Shea, who had only been instructed on the preceding Friday, sought to amend the grounds of appeal to include the cancellation of registration as a registered manager. Initially Mr. Saigal objected on the basis that this was a very late application and the response to the appeal had been prepared on the basis there was only one appeal. The Tribunal heard their submissions and investigated any possible prejudice. It was identified that in reality there would be little difference as Miss Udoh is both the registered manager and provider of what is a very small domiciliary care agency. Mr. Saigal then had instructions not to oppose an amendment, accepting that it was proportionate for both grounds to be heard in the one appeal. The Tribunal agreed and gave leave to amend the grounds of appeal.

The Setting and background:

6. The Appellant, 100% Care Services is a provider of domiciliary care who has been registered with the CQC since 9 November 2018. It is a very small operation, with just five or six service users. The registered office is also Miss Udoh's home.

7. Initially the service had two clients. Following another domiciliary service Careworld shutting down, the service took on three new clients.

8. The CQC was contacted by Selma Ghouse, senior contracts officer for the London Borough of Newham on 14 May 2019 regarding concerns about the Appellant. They had concerns about the Appellant's failure to carry out robust recruitment checks and failure to have risk assessments and care plans for service users.

9. It was this communication that triggered the need for an inspection. Information was shared by the Local Authority and Mr Boakes was the Inspector nominated to carry out an inspection on 22 May 2019. This was the first inspection of the service. It was an announced inspection with 48 hours notice. It's overall rating was 'inadequate' and the service was placed in special measures.

10. At the point of that inspection the service had only six service users.

11. On 24 May 2019, the Local Authority notified CQC that they had made the decision on 24 May 2019 to remove all six service users and place them with alternative providers. The service has not functioned since.

12. On 4 July 2019 CQC was served with notification that the Local Authority was formally suspending placements at the service because of unsafe recruitment practices, failure to demonstrate assessing and documenting person-centred care, unsafe medicine practices, failure to meet the Mental Capacity Act 2005 and failure to establish good governance systems and processes.

13. The initial approach of the Care Quality Commission was that whilst the breaches were serious, the first step on 7 June 2019 was to impose a condition restricting new clients without prior written permission of the CQC. This was not a suspension, so the Appellant could still operate. It was seen as proportionate by the Respondent in the light of the action being taken by the Local Authority. Concern was raised when the Appellant emailed on 4 June 2019 following the suspension of care packages by the Local Authority, asking if they could take on private clients or clients from other local authorities as this did not acknowledge the concerns that had been raised or demonstrate an understanding of the clear conditions that had been set.

Procedural Issues:

14. In the lead up to a final hearing, this case raised a number of interlocutory issues, which we record as they are symptomatic of a number of failures to

comply with directions of both the tribunal and the regulatory process.

15. The Appellant applied to vacate the telephone case management hearing on 24 September 2019 as the legal representative was attending the wedding of her daughter. The application was granted, and an order made requiring the parties to exchange witness statements and evidence no later than 4 pm on Monday 21 November 2019. There was no response from the Appellant and the CQC sent a chasing email at 17. 15 pm that day.

16. The solicitors responded with the explanation that the Appellant had an eye infection and this was causing delay in her responding. The Appellant served a witness statement on 13 December 2019, but it was dated 13 November 2019.

17. The CQC made an application to strike out. The strike out application was heard by Judge Khan in a telephone hearing on 23 December 2019. Neither the Appellant nor her representative attended. Dr. O'Shea said that he was instructed that they had tried to dial in on the number given but it had not worked. The Tribunal queried why this has not been brought to the attention of the tribunal administration, with an apology for non-attendance and a request for a new date if still required.

18. Judge Khan made an 'unless' order ordering compliance by 6 January 2020, which was complied with. However, the Appellant's representative did not attend the final TCMH on 10 February 2019.

Applications at the final hearing:

19. The first application as recorded above, was an application to amend the grounds of appeal.

20. Dr O'Shea raised no objection to the Respondent's renewed application to submitting a second witness statement for Darren Boakes, a statement from Alison Murray and various documents relating to the CQC enforcement process. He confirmed that he'd had a full opportunity to consider those documents over the preceding weekend. Accepting that they were relevant to the issues under consideration the Tribunal agreed to admit them as well as the skeleton arguments drafted by both representatives.

21. At the end of the first day Dr O'Shea applied to submit a bundle of assorted care plans, risk assessments and support plans, he had just been shown by his client. Initially Mr Saigal opposed the very late application. Mr Boakes confirmed that he had not been sent these documents after the inspection on 22 May 2019, although other documents had been sent. He considered the documents and emails he had been sent overnight and re confirmed the that CQC had not been sent the bundle that Dr O'Shea was now producing. Mr Saigal noted that some of the dates on the front page had been tippexed over and were inconsistent. He therefore did not accept that they were prepared in April 2019 as claimed but agreed that the Tribunal could consider them as part of their overall consideration, attaching such weight as they thought

appropriate, which given the inconsistent dates might be adverse to the Appellant.

22. On the morning of the third day of this hearing Mr O Shea produced a certificate of insurance from 22 May 2019, which been previously referred to as evidence. The certificate seen at the inspection ended on 14 May 2019, so there was a gap. That breach was not relied upon given the later certificate, save that the Respondent asserted it was another example of Miss Udoh not being on top of the relevant paperwork and need for compliance.

23. The Appellant had only one witness Mr Chuks Okoh, who was a care worker who had transferred to her service from Careworld. She said he'd written his statement dated 4 February 2020. He had been due to attend on the afternoon of the second day. Mr Saigal clarified that the original position of the CQC had been that they would require him as a witness, as they did not accept with his statement. Being mindful that the witness needed to be at work, he was content to leave the weight to be accorded to the statement to the Tribunal. He raised that it was in similar style to the Appellant's statement dated 6 January 2020 and exhibited to it, although it was dated 4 February 2020. Mr Okoh contradicted the Appellant who had said that no service users were given medication. He went further and said that when 100% Care Services Ltd wanted to change the MAR chart he refused because there was an instruction from the Careworld agency that CQC wanted all carers to use the pharmacy MAR charts. The Tribunal reiterated that it was a matter for the Appellant which witnesses she called but queried the relevance of the statement as much of it was directed to defending Mr. Okoh's care of the service user whom he had looked after for some years. It was compliance with the Regulations that was in issue, not the care provided by the care workers.

Regulations and Guidance

24. The representatives agreed and the Tribunal accepted that the regulatory scheme and law as set out in the skeleton argument prepared on behalf of the Respondent was correct.

25. Section 20 of the Health and Social Care Act 2008 (HSCA 2008) provides for the Secretary of State to make regulations in relation to regulated activities. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the Fundamental Standards which providers must comply with when carrying out a regulated activity.

26. The relevant regulations for the purposes of this appeal regulations 9, 11, 12, 17 and 19 of the 2014 Regulations.

27. Regulation 21 of the 2014 Regulations provides that the registered person must have regard to the guidance issued under section 23 HSCA Act 2008. In relation to Adult Social Care, there is also guidance issued to CQC.

Legal Framework

28. The Power to cancel a provider's registration is governed by section 17 of the HSCA 2008, which in relevant part states: -

> "s.17 Cancellation of registration
> (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)……
> (b)……
> (c) on the ground that the regulated activity is being or has it any time being, carried on otherwise in accordance with the relevant requirements.

29. Section 4 HSCA 2008 provides that the CQC must have regard to various matters when exercising any of its functions.

30. The burden of proof is upon CQC who must establish the facts upon which he relies to support cancellation on the balance of probabilities.

31. The powers of the Tribunal on an appeal are set out in section 32 HSCA 2008. It determines matters afresh. It is not simply reviewing the decision of the Respondent, so may take into account the evidence/improvements since the Notice of Cancellation was issued. It may either confirm the CQC's decision to cancel or direct does it shall not have affect. If the Tribunal decides that cancellation should not have effect, it may impose conditions on the Appellants registration or remove any of the current conditions.

32. Essentially, the Tribunal has to determine and make findings of fact as to:-
a) Was there a breach of the Relevant Requirements and
b) If so, is Cancellation of the Registration a proportionate and necessary. step

<u>The breaches of the Regulations.</u>

33. These were set out in detail in the first statement of Darren Boakes, who spent 5 to 6 hours at the service and specifically examined the care records of Service Users A, B, C and D.

<u>Regulation 9-person centred care:</u>

34. There was no care plan for service user A, although the records from the London Borough of Newham stated that the medical history was chronic kidney disease, hypertension, doubly incontinent, pressure sores, pacemaker and left-sided sided cerebral infarction.

35. There was no care plan for service user B. The information from the London Borough of Newham was a medical history of pressure sores, right hip pain, fibromyalgia and asthma. They were at risk of falls and neglect.

36. There was no care plan for service user C. The background information from the London Borough of Newham was that they had a knee replacement, arthritis, right shoulder and hand tear, depression and large tibial enchondroma.

37. There was no evidence that Service users A, B and C had been consulted on the development of the care plan.

38. Service user D did have a completed risk assessment and care plan at the time of the inspection. However, care records did not in the view of CCQ identify any protected quality characteristics or cultural and religious needs, so as to ensure service users received individual and person-centred care.

Regulation 11- need for consent

39. On 22 May 2019, the care records of service users A, B and C did not contain any records of any capacity assessments, which the Appellant said was due to their families ignoring her request to meet with them. She provided no evidence to back up that assertion.

40. The Appellant told the inspector that Service user D had a power-of-attorney (POA), which she had not seen. When the inspector spoke to their relative, they advised that there was no POA and that D did not have the capacity to make decisions.

Regulation 12-Safe care and treatment.

41. The concern was that no individual risk assessments have been carried out. In particular service user D has had a fall in the home on 12 April 2019 and had to be taken to hospital.

Regulation 12-medicines.

42. The appellant had told the inspector that none of the service users were supported by medicines. This contradicted the evidence of Mr. Okoh and her own later evidence. The information from the London Borough of Newham said that they needed support with medication as they were forgetful.

Regulation 17-Good Governance.

43. The CQC pointed to the lack of insurance, at least for a limited period. The local authority visited the service on 3 April 2019 and highlighted concerns, including the service users who did not have risk assessments or care plans in place and that safe staff recruitment practices were not being followed, but no action was taken.

Regulation 19 -staffing.

44. The Inspector looked at 4 staff records, but each was inadequate. She had failed to ensure that she had carried out the necessary checks including a

DBS check and satisfactory evidence of conduct in previous employment. For four members of staff, there were no records of being interviewed. For one member of staff employed by the Appellant the two references did not match the reference named on the application form. Another member of staff employed by the Appellant had no references on their file.

45. These are set out in the Scott Schedule.

The Evidence:

46. The Tribunal carefully considered one bundle and the supplementary bundle of documentation. We very carefully considered all the written and oral evidence but we only briefly summarise such evidence as is necessary to explain the Tribunal's decision and in further detail as necessary to support our conclusions.

47. The Tribunal fully used its inquisitorial powers, took a proactive approach and asked a number of questions. We did allow a degree of flexibility, as at points this was the proportionate way to cut through. It also recognised that Dr. O'Shea had only been instructed very shortly before the hearing.

48. Mr Boakes had set out the history and breaches in close detail in his witness statement. The oral evidence focused on the Appellant's approach and manner and what documents had subsequently been sent to him.

49. He clarified that this was an announced inspection, such that the Appellant had 48 hours notice of it. Prior to the inspection, he had been contacted by the Local Authority and received an email from Selma Ghouse on 20 May 2019 which included a report of the monitoring visit undertaken on 3 April 2019. He denied the Appellants suggestion that he had somehow conspired with Ms Ghouse. Sharing information was part of good practice and required by the Regulations.

50. It is a key part of the Appellants case that she was very distressed that day, due to the terminal illness of her sister-in-law. He said that she had not told him that nor did she seem distressed. Had that been made known to him, he would have considered adjourning the inspection. She gave that information in an email dated 17 June 2019.

51. She told him that the handwritten risk assessments had been carried out externally but couldn't remember if she mentioned the author, Mrs. Sharon Whyte specifically. She did not want to show them to him, as she said that she needed to type them up. It was the Appellant's case that he had adopted an approach of 'if he did not see it, then it did not exist.' However, it was common ground that he gave her 48 hours to send in additional documents. At the end of the inspection he fed back his concerns, which she signed. It stated that all other information was to be received by 'Close of business Friday 24 May 2019'.

52. Mr Boakes's second statement is a detailed response to the Appellants first statement. He made clear that the decisions of the Local Authority in

relation to place no more service users, was their decision and he had played no part in it. It is agreed that the Appellant had not taken up the opportunity to have that decision reviewed.

53. In accordance with the usual CQC practice, the Appellant had the opportunity to comment on the factual accuracy of the report. We read her comments which were in large part an attack on the inspector and strongly advanced her view that there was a conspiracy against her by the CQC and Local Authority.

54. Again, in accordance with the usual practice Mr. Boakes fed back to Ms Lynes, who was the decision maker. They did not move to a cancellation just a restriction, but the documents recorded the concern that the Appellant did not seem to understand the severity of the concerns. At no point did they receive an Action Plan or information on how the Appellant was going to improve the service.

55. When cross-examined, Dr O'Shea advanced the Appellant's explanation about the insurance certificate, which automatically renews was that she had wanted to upgrade the insurance. She said she had been told by the insurance company that she was covered for the intervening period, until the new certificate started on 22 May 2019. She had already provided a bank statement showing a direct debit going out on 15 May 2019 but coming back into the account on 21 May 2019. She asserted that the insurance company told her at the end of day one when she rang them, that she was covered in the intervening period. She said she couldn't provide written documentation to back that up as she had been told that the person who was dealing with her case, was on leave.

56. Miss Udoh said that she had drafted her own statements. She set out that she was a law graduate, who additionally had a Masters degree in law, both from the United Kingdom. She had supported her studies by working as a care worker, for some years. Then she spent some time in Nigeria where she was called to the Nigerian Bar in 2013.

57. She then returned to the United Kingdom where she worked as a paralegal. She then joined the recruitment department of Focus Care Link for a year and a half, so became familiar with recruitment requirements.

58. She stated that it was very important for her that good care was given, because her late mother died due to abuse in care. She became very emotional in the witness box, when she recalled that.

59. She clearly stated in her witness statement and again in the witness box that she believes that there was a conspiracy between Selma Ghouse and Darren Boakes whose manner and body language had been very threatening to her on the inspection. She said it was a 'cover-up' between them and that he was biased.

60. Her view of things was that thereafter she was bombarded with requests

and queries, when she was bereaved. She was the only relative available to support her sister-in-law through her final illness and thereafter was expected to arrange repatriation of the body to Nigeria. This placed her under considerable emotional and financial pressure. It was clarified that a funeral took place in the UK in July 2019, but that the Appellant had been out of the country for a period in Nigeria taking back personal possessions.

61. Time was spent examining exactly which risk assessments she subsequently sent to CQC, but there was no clear email trail to back this up and Mr Boakes was clear that he had not been sent the documents submitted as late evidence. In particular, he had taken the opportunity overnight to go through the documents and emails again, but there was no record of having received them.

Conclusions and Reasons.

62. In reaching our conclusions we have had regard to all the evidence, the written skeleton arguments and oral submissions made on behalf of both parties.

63. Overall our view of this case is that CQC had advanced a detailed case supported by evidence as to the breaches of the relevant Regulations and their high level of concern. The oral evidence instead of reducing some of these concerns or removing them, highlighted that the Appellant was unable to engage with the breaches of the regulations and take steps to remedy them. Instead, she remained convinced that she had been the victim of a conspiracy between the CQC and the London Borough of Newham. She sees herself as a victim of bias. Regrettably we must say, that we found her evidence to be unreliable, inconsistent and at times emerging for the first time when she realised that she needed to give an explanation.

64. The inspector Mr. Boakes was the subject of a very personal attack by the Appellant. We found his evidence to be calm, thoughtful and professional. The case doesn't just turn on his evidence. He followed the CQC internal processes. His inspection findings were triangulated with other evidence obtained from the local authority. Further, he was not the ultimate decision maker. Additionally, the Appellant did not seek opportunities available to her to put forward new evidence and have her case reviewed by an independent panel.

65. We agree with representatives that this is not a case where it is necessary to make detailed finding on each allegation in the Scott Schedule. Instead the case turns on the Appellant's ability to grasp the issues. We have examined the explanations that she gave with great care. We conclude that she was not able to give a coherent explanation of how she had complied with the Regulations or if she was not doing so, what she had done about it. This should be a straightforward matter of putting forward an explanation and her documents to support it.

66. Any registered provider/manager must comply with the Regulations, show

an ability to be on top of paperwork and to put forward supported explanations with evidence when required to do so. The Appellant raised the fact that she is a trained lawyer with a background in recruitment. That is a side issue. However, it makes it all the more surprising that she has so manifestly failed to understand the concerns, engage with processes and to challenge decisions that she does not agree with. It also applies to processes within the local authority, the CQC and the Tribunal appeal process.

67. The Tribunal adopted a very flexible approach, so that the Appellant had a full opportunity to put her case. We were struck that despite both representatives and the Tribunal giving her an opportunity to say what she would do differently, her only response was that she would not have taken on the service uses from Careworld. When asked an open question by the Tribunal Judge at the end of her evidence, as to whether there was anything else she would like us to consider, she could only say that she was surprised that Mr. Saigal had not asked her more questions about bias and conspiracy. At no point did she express any real remorse or regret or lessons learnt, other than not taking on the service users and that she would work on the risk assessments. As she has such a firm view that she has been the victim of conspiracy and bias, it is perfectly logical on her thinking, that she does not need to make changes.

68. We find that the Respondent has discharged the burden of proof and established on a very clear balance of probabilities the breaches of the Regulations set out in the skeleton argument namely regulations 9, 11, 12, 17 and 19. It is a concern that of the relevant regulations are set out in Regulations 9 to 19 2014, and she was in breach of over half. We remind ourselves that these are minimum requirements and any provider/manager must be expected to be conversant with them and comply with them.

69. The local authority and CQC have different responsibilities. The Appellant had a new business and benefited from the shutdown of Careworld agency. It meant that she obtained three new clients. The local authority made very clear to her what their concerns were in the monitoring visit on 3 April 2019. This, on our analysis is the first example of where the Appellant seemed unable to grasp the high Stage 3 level of concerns that was been raised and that she needed to take action. She did not seek a review. That is the first example of where she did not seem to understand processes and remedy.

70. We reject he assertion that the local authority was somehow and for some unspecified reason conspiring against her, with the CQC. That is her view, but it is not supported by any objective evidence. In cross-examination she couldn’t suggest why they would do that.

71. Mr. Boakes was aware of the local authority concerns, which as he set out was the reason of the announced inspection on 22 May 2019. This was an example of how the CQC must work in cooperation and have regard to concerns raised: see section 4 HSCA 2008.

72. This was on any view, a tiny service, just six service users. The Appellant

has had from 3 April 2019 to put things right and 48 hours' notice of the inspection. Instead what Mr. Boakes found was a chaotic state of affairs and documentation requested not being available.

73. There was no public liability insurance, but there that is not relied on by the CQC as there was from 22 May 2019. Despite the length of these proceedings the Appellant has not provided any convincing evidence other than her oral assertion that there was cover from 14 May to 21/22 May 2019. If that really is what she was told by the Insurance Company, then she had plenty of time to get that explanation in writing, rather than making a call on day one of the hearing and been told apparently that the relevant person was on holiday.

74. The Appellant was unable to produce risk assessments. We have looked at the profile of the 4 service users and it is self-evident why risk assessments were needed. Given that the service users have previously been supported by a failing care agency, that made the need for up-to-date assessments even more urgent. The explanation is that this work had been outsourced. The Appellant was not able to give any coherent explanation of what exact role the external assessor had. Again, it was all part of a chaotic picture of the Appellant paying the assessor but needing to re-write the assessment herself on her evidence, in more detail.

75. Such care plans as were produced were inadequate. We do not accept that she shared the care plans, which were the subject of the late evidence with the CQC. It is accepted that she sent some further evidence, but she could not produce an email trial to show these documents had been sent. When pressed on that she said that the documents had bounced back as the files were too large. She then suggested she posted them and said she had proof of that, but we had no evidence of that, although she said she had sent it registered post. She then seemed to blame her solicitor.

76. With regard to these late produced care plans and assessments, the Appellant has effectively produced evidence against herself. The dates, as with so many other dates on the evidence in this case are inconsistent. Having felt the original, it is clear that one date is tippexed out. The date the service starts is changed to '2/4/19' but the date of the plan is 22/4/19, although the first digit has been written over. Moreover, even a cursory glance through the documents shows a large number of other dates are clearly incorrect. As just one example that the assessment was carried out by Ms. Whyte on 22/05/19 but the review date is also 22/05/2019. On other documents his name is mixed up with a female name and a different address for the service. We did not go into this in detail as the tipexed date change and very late production is sufficient for us to conclude that we detach very little weight to these documents. They are part of an overall chaotic picture, when it would be reasonable to expect accurate and straightforward documentation.

77. We then examined whether there were any reasonable excuses for the Appellant's lack of compliance and engagement, with what are minimum standards. The explanation appeared to be the illness of her sister-in-law and that she was under pressure, including financial pressure to make the funeral

arrangements. It is a further inconsistency. On the one hand she was saying that she was in deep grief and unable to function. When it was put to her in cross-examination that that might have been a reason for a career break, she said it was not necessary and that she had 'moved on' in July 2019 following her sister-in-law's funeral.

78. There was not one managerial aspect of the service that was working well. Registration at Companies House was terminated because she had not filed the appropriate documents, which she said was due to her being in Nigeria. It is not clear why that prevented her filing the relevant accounts electronically.

79. If she was in difficult personal circumstances, then the notices she was served with made clear that there were time limits. She could seek a time extension with supporting evidence if she needed that.

80. We have deliberately set out her lack of engagement with the Tribunal Process. The Tribunal pointed out a number of points that she was obliged to assist the tribunal. She then for the first time blamed her solicitors. The Tribunal guided that these were serious allegations and that without hearing from them, would not accept that explanation.

81. Any service provider/manager should understand the regulations, have appropriate paperwork and if they do not, be able to produce it quickly or offer an explanation. On any view the Appellant's reaction to paperwork and process was chaotic, completely belying her stated legal training.

82. Dr O'Shea, who was only briefed on Friday 14 February 2019 and said everything that reasonably could be said on behalf of the Appellant but realistically had to recognise the gaps in her case and that his client as he put it, had a certain perception of events.

83. Dr O'Shea guided us to look at the level of the breaches and that there have been no complaints about the care of the service users. It is an unattractive argument to say that no harm occurred and that is not the legal test.

84. We have no hesitation in finding that there was a very clear risk of harm to the service users. Lack of risk assessments meant that risks could not be minimised. Care plans are particularly important as a record of individualised needs and personalised care, actions and responsibilities. While some of the individual carers may have known the service users for some time, those carers would not always be available. We agree with the evidence of Mr Boakes, that a new carer who had not previously supported the service user should be able to go into the home and offer appropriate care. That is particularly important in a domiciliary service, where there are no other staff around to ask.

85. There was no clear system to make the care plans available, easily understood and updated. There was not a copy in the service user's home and one with the service user/manager, so that she could give guidance if she needed to. This again clearly establishes a risk of harm.

86. This was compounded by a lack of risk assessment, for what was clearly a very vulnerable cohort of service users. Given our assessment of the Appellant's reliability, we reject the suggestion that she's been trying to get in touch with the service users families. It is an assertion not supported by written evidence. Even if she had and they were not cooperating that would not have stopped her doing a risk assessment and revising it once she had managed to speak to the families.

87. We reject the submission made on her behalf, that she should be given the benefit of the doubt and a further opportunity to operate the service. She has had every opportunity to put things right even if she didn't at the time of the inspection. We are of course looking at the evidence of the date of the hearing.

88. The Appellant has been in operation since November 2018 and should have been continuously compliant. The Appellant has been on notice of the shortcomings since the monitoring visit with the local authority on 3 April 2019, yet there was no improvement by the time the CQC inspection took place some seven weeks later on 22 May 2019.

89. The Appellant remains fixated on the alleged conspiracy. Her attitude towards the regulator is not one of respect and an understanding that she must work in cooperation with them. She continues to be very hostile and continues to question the motives and integrity of professionals doing their job and has expended her energy on trying to put the blame on the local authority and the CQC rather than remedy the clear defects in her service.

Conclusion:

90. The CQC have made out their case. They have put together factual detailed evidence to support each allegation made. The breaches set out in the skeleton argument and Scott Schedule are made out.

Proportionality

91. The care provider and the Appellant personally as the registered manager, has had numerous opportunities to address the deficiencies and comply with the Regulations. Compliance notices have proved ineffective in securing compliance. She was also the nominated individual, so there was no other person involved in the service who might have been able to balance her lack of ability and insight.

92. The Appellant has consistently failed to comply with the Regulations. Accordingly, we dismiss the appeal and uphold the decision to cancel the registration. We do not consider that conditions are appropriate or practicable when the Appellant has already been provided with numerous opportunities to bring about change. None were suggested to us as workable.

Decision

The appeal is dismissed.

The decision of the Care Quality Commission dated 12 July 2019 to cancel

i) the registration of 100% Care Services Ltd as a service provider Is upheld and

ii) ii) the decision to cancel the registration of Esther Udoh as the registered manager is upheld.

Judge Melanie Lewis
Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 26 February 2020