First-tier Tribunal, Care Standards Tribunal

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

[2022] 4747.EA
Neutral Citation Number: [2024] UKFTT 00258 (HESC)

Hearing held on 26, 27, 28 and 29 February and 1 March 2024 at Birmingham Civil & Family Justice Centre (deliberation on 1 March 2024 and 6 March 2024)

Before
Ms S Brownlee (Tribunal Judge)
Mrs Libhin Bromley (Specialist Member)
Ms Pat McLoughlin (Specialist Member)

Between:

Sentricare Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

Preliminary note

1. Prior to the hearing, the Tribunal made an order pursuant to Rules 14(1)(b) of the Tribunal Procedure Rules 2008, prohibiting the disclosure and publication of any matter likely to lead members of the public to identify persons the Tribunal considers should not be identified.

The appeal

2. This is Sentricare Limited's ('the Appellant') appeal against a decision of the Care Quality Commission ('CQC' and 'Respondent') to vary its conditions of registration so that the regulated activity of "personal care" shall not be carried out from the location of Sentricare Birmingham, Bartlett House, First Floor, 1075 Warwick Road, Acocks Green, Birmingham B27 6QT. Mr Justin Mazengwa, the nominated individual and registered manager of Sentricare Birmingham ("SB") brings the appeal, on behalf of the Appellant and is, in effect, also the Appellant. Mr Mazengwa appeals the Respondent's decision of 28 September 2022 pursuant to section 32 of the Health and Social Care Act 2008 ('the Act')

to the First-tier Tribunal ("the Tribunal").

The hearing

3. The hearing took place from 26 February to 1 March 2024. It had a time estimate of five days. The parties and all witnesses attended the hearing at the hearing venue in Birmingham.

4. In advance of the hearing, the Tribunal had read the digital hearing bundle (running to 10435 digital pages) and skeleton arguments from both parties. The Tribunal used the reading list, agreed between the parties, focusing its advance reading on the essential and recommended reading, in light of the volume of the hearing bundle.

5. Some participants worked from hard copy hearing bundles and some from digital hearing bundles. All witnesses used the hard copy hearing bundles, apart from Mrs Caroline Higgs, who used the electronic hearing bundle on her own laptop/tablet.

Attendance

6. Mr Mazengwa was represented by Ms Amy Oliver, counsel, instructed by Ms Lauren Wilson from Markel Law. The Appellant called two witnesses to provide oral evidence, namely Mr Mazengwa and Mr Andy Fairman, quality and compliance consultant. The CQC was represented by Mr Vishal Misra, counsel, instructed by Hill Dickinson LLP/CQC Legal. The Respondent called four witnesses to provide oral evidence, namely, Mrs Laura Wilkes, inspector, Mrs Lisa Clewley, inspector, Mrs Caroline Higgs, inspector and Miss Amanda Lyndon, interim deputy director of operations. Mrs Lee-Ann Frampton Anderson and Ms Karen Antwi, solicitors from CQC Legal, attended on various days.

7. The hearing was held in public. An order, made pursuant to Rule 14(1)(b), prohibiting the publication of any matter likely to lead members of the public to identify any person who the Tribunal considers should not be identified. Accordingly, in this decision, a staff member and all service users are anonymised.

Late evidence applications

8. At the beginning of the hearing, the Respondent indicated that it wished to adduce a fourth witness statement from Mrs Laura Wilkes, who is the lead inspector for SB. Mrs Wilkes' witness statement had been served on the Appellant on the morning of the first day of the hearing, having been signed and dated 25 February 2024. It was made in direct response to the Appellant's late evidence, which consisted of a mock assessment report dated 12 February 2024 from Mr Richard Pindani, compliance consultant from Shannon Health Care Ltd. The Tribunal had granted the Appellant's application to admit Mr Pindani's report on 23 February 2024.

9. The Appellant objected to the admission of the witness statement, on the basis that there was not much value in Mrs Wilkes' fourth witness statement, as it consisted of comment, arguments and submissions, which should be made by the Respondent's counsel. Ms Oliver submitted that it would be unfair to admit the statement and if Mrs Wilkes wished to make comments on Mr Pindani's report, she could do so in oral evidence. Ms Oliver also made the point that Mr Pindani had produced a previous report in September 2023 and Mrs Wilkes had not considered it necessary to produce a witness statement in response to that report.

10. The Tribunal took time to consider the application and response. The Tribunal applied Rule 15 of the Tribunal Procedure Rules 2008, which provides a wide discretion to admit evidence, even if not admissible in a civil trial in England and Wales and/or evidence which was not available to the previous decision maker. The Tribunal considers the decision to vary conditions of registration afresh in what is a 'de novo' adjudication. The Tribunal took into account the timeline with this evidence. The Respondent acted reasonably in providing a written response from Mrs Wilkes in the form of the fourth witness statement. It could not have produced it sooner, in the Tribunal's view, given that it was not aware of the Tribunal's decision on the admission of Mr Pindani's report until 23 February 2024; the last working day before the hearing was due to start.

11. The Tribunal considered the nature of the evidence – it is of relevance to the decision the Tribunal makes on appeal. It is evidence which sets out the rationale as to why the Respondent has not changed its position, having considered the contents of Mr Pindani's report. As to unfairness, the Tribunal took into account that the witness was available to give oral evidence and answer questions from the Appellant. If her witness statement was not admitted, there would be no bar on the Respondent's counsel simply asking the questions to elicit Mrs Wilkes' views on Mr Pindani's report. There is no unfairness which could not met with counsel for the Appellant probing the views of Mrs Wilkes through cross examination. The Tribunal reached its decision with application of the overriding objective. We concluded that the considerations at Rule 2 (a), (b), (c) and (e) were met, which led the Tribunal to decide that the admission of the witness statement, just before the hearing started, was fair, just and proportionate.

12. At the end of Mr Mazengwa's oral evidence, Ms Oliver applied to admit two documents by way of late evidence, in response to points which Mr Mazengwa had developed during his oral evidence. The Respondent did not object to the admission of the documents. The Tribunal admitted them, taking into account the serious nature of the appeal and the potential consequences for the Appellant. The Tribunal admitted a screenshot of Mr Mazengwa's email account, which indicated that he had begun an email response to send to the Respondent in response to its request made under section 64 of the Health and Social Care Act 2008 and an email sent from a CQC inspector ("Inspector IS") to Mr Mazengwa on 21June 2023.

Background

13. The Appellant is currently registered to provide the regulated activity of 'personal care' from two locations pending the outcome of this appeal. The Appellant has been registered with the CQC to provide 'personal care' from the SB location since 29 September 2020. It also has a condition of registration which permits it to provide the regulated activity of 'personal care' from a second location, known as Sentricare Walsall. Sentricare Walsall has provided its regulated activity since 1 October 2010.

14. SB provides support to service users living in their own homes, including children from ages 0 to 18, young adults, people living with dementia, learning disabilities, Autism, mental health issues, physical disabilities, sensory impairments and older people. Mr Mazengwa is the registered manager at both locations. At the moment, it provides personal care to 59 service users and has 57 carers as contracted staff.

15. SB was first inspected between 21 December 2021 and 11 January 2022. At that time, it was providing personal care to 240 service users. The domains of safe and caring were rated 'requires improvement and the domains of effective, responsive and well-led were rated 'good'. Therefore, SB received an overall rating of 'requires improvement' with no breaches of the 2014 Regulations.

16. Birmingham City Council had informed the Respondent of a visit they had carried out at SB in May 2022, during which it had noted significant concerns with leadership, data, quality assurance, investigation of incidents/accidents, a lack of a business continuity plan, complaints policy and procedure and information security concerns. As a result of the local authority's concerns, it concluded BS was acting in breach of its contract and the decommissioning process was started.

17. As a result of the information shared by Birmingham City Council, the Respondent decided to conduct an unannounced inspection, which took place between 5 and 26 July 2022. At that time, Staff Member 21 ("SM21") was the nominated individual and Mr Mazengwa was the registered manager. Mr Mazengwa was not in attendance for the inspection as he was in Zimbabwe. Following the inspection, the Respondent made a number of safeguarding alerts, including one service user's safeguarding which led to an investigation under section 42 of the Care Act 2014, on the basis of there being cause to suspect that an adult is experiencing or is at risk of abuse or neglect. The Respondent found the Appellant to be in breach of nine of the 2014 Regulations and rated the Appellant as 'inadequate' in all five domains.

18. The Respondent issued a notice of proposal on 22 August 2022. The Appellant provided written representations on 5 September 2022 and on 28 September 2022, the Respondent issued its notice of decision, in which it decided to adopt the proposal to vary a condition of registration to remove the SB location.

19. On 26 October 2022, Mr Mazengwa submitted an appeal against the Respondent's decision, to the First-tier Tribunal.

20. The Tribunal agreed to stay the appeal to allow the Respondent to conduct a further inspection. The appeal was stayed until early 2023, to allow the Respondent to complete an inspection, which took place between 12 December 2022 and 12 January 2023. The Respondent found the Appellant in breach of ten of the 2014 Regulations and rated the Appellant as 'inadequate' in all five domains.

21. In preparation for the appeal hearing, which was originally listed to take place in October 2023, a third inspection took place between 1 and 16 August 2023 and the Respondent found the Appellant in breach of ten of the 2014 Regulations and rated the Appellant as 'inadequate' in all five domains.

The legal framework

22. Section 2 of the Health and Social Care Act 2008 ('the 2008 Act') invests in the Respondent registration and review and investigation functions. By virtue of section 3(1) of the 2008 Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.

23. Section 4 of the 2008 Act sets out the matters to which the Respondent must have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.

24. Section 12 of the 2008 Act obligates the Respondent to grant an application as a service provider where the Respondent is satisfied that the requirements of the Regulations (amongst other things) are being and will continue to be complied with in relation to the regulated activities. If it is not satisfied, it must refuse it.

25. Under section 20 of the 2008 Act, the Secretary of State is empowered to make regulations in relation to the regulated activities by way of regulations. The Regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ('the 2014 Regulations') and The CQC (Registration) Regulations 2009.

26. Sections 26, 27 and 28 of the Act set out the procedural requirements in relation to notification of the Respondent's decision.

27. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to vary the conditions of the registration of a service provider in relation to a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect. Under section 32(6), the Tribunal also has power to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates. A 'discretionary condition' means any condition other than a registered manager condition required by section 13(1)

of the Act.

28. Part 3 of the Regulations sets out the Fundamental Standards that registered providers must comply with when carrying on a regulated activity, which includes Regulations 9, 10, 11, 12, 13, 16, 17, 18, 19 and 20.

29. The Respondent bears the burden of establishing that it is more likely than not that the 2014 Regulations have not been complied with at the date of the hearing, including 'by having regard to' guidance issued under section 23 of the 2008 Act. The findings of fact are made on the basis of whether or not the Tribunal is satisfied as to the facts on the balance of probabilities.

30. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing. Subject only to relevance and fairness, this can include new information that was not available or presented at the time when the decision under appeal was made and the information can be admitted as evidence in the appeal, even if it were not admissible in civil proceedings in England and Wales. The fresh determination in this appeal includes consideration of the detailed documentary evidence provided by both parties, as well as the oral evidence, subject to questioning over the five days of the hearing. We have considered all of the evidence and the written submissions before us, even if we do not mention every point of it in our decision. We refer only to the parts of the evidence which were of particular importance in reaching our findings, noting that the proceedings were audio recorded throughout the public hearing and both parties had made arrangements to take a note of the evidence.

The parties' positions

31. At the outset of the hearing, the Tribunal clarified the Appellant's position, in line with the Scott Schedule, completed by both parties. Broadly speaking, the Appellant's position was that the breaches of the Regulations identified by the Respondent at the inspections of July 2022 and December 2022/January 2023 were reasonable and accepted by him. His position was that by the time of the August 2023 inspection, the Respondent had closed its mind to any other rating than inadequate as the lead inspector (Mrs Wilkes) was biased in her approach, which meant there was a lack of proper emphasis on the improvements made by the Appellant.

32. The Appellant brought the appeal on the following grounds, which were set out in the grounds of appeal accompanying the appeal application of October 2022 and the skeleton argument prepared on the Appellant's behalf in January 2024 and the Appellant's closing arguments.

33. The Appellant contended that:

    (a) He has accepted a significant number of issues (as set out in the Scott Schedule) as issues at the time of the inspections.

(b) He has provided evidence of significant improvement and demonstrated an ongoing commitment to high quality care.

(c) The Respondent did not undertake a fair and balanced assessment of the current service from SB, given that the most recent inspection took place in August 2023 and without taking into account relevant information from the Appellant about changes.

(d) The Respondent has demonstrated a lack of impartiality and a prejudicial approach to him.

(e) The Appellant was significantly affected by the actions of the previous Nominated Individual, staff member 21.

(f) There have been sufficient improvements to the service, which means it will improve its rating at if inspected today. Mr Mazengwa has demonstrated a commitment to improvement since ending the employment of staff member 21, taking over the role of nominated individual and contracting with two external consultants to bring the service into compliance.

34. The Respondent defended the appeal on the basis that its decision-making process and the decision subject to appeal have been fair, reasonable and proportionate at each stage. The Respondent relied upon the regulatory history of SB which demonstrated that for the past three inspections, the overall rating has been inadequate. The Respondent strongly refutes any suggestion its inspectors have acted in a partial or biased manner in their approach to the regulatory process and submits that its decisions, at each stage, have been based on clear evidence of widespread breaches of the Regulations.

35. The Respondent's position remains unchanged in light of the follow up inspection it completed in August 2023 and in taking time to consider the updated documentary evidence from Mr Mazengwa, the Respondent does not consider it is sufficient to allay its evidence informed belief that the Appellant does not have the competence, skills and systems to ensure any improvements are embedded, can be sustained and will demonstrate compliance with the Regulations.

Evidence

36. The Tribunal had the benefit of signed witness statements from all witnesses called to provide oral evidence. The lead inspector, Mrs Wilkes, had provided four detailed witness statements. Mr Mazengwa has provided three detailed witness statements, made at a number of significant points in the chronology of the appeal.

37. Mrs Wilkes exhibited all documents provided by the Appellant as part of each relevant inspection, as well as relevant communication chains and inspection reports. The Tribunal had copies of all relevant inspection reports and a large number of records for service users, some anonymised and some not. The oral and documentary evidence is referred to only as it is required to explain our

findings and conclusions. The Tribunal noted that the public hearing was recorded and therefore we do not consider it necessary to set out a lengthy summary of the oral evidence.

The Tribunal's conclusions with reasons

38. For the reasons which follow, we have decided to direct that the Respondent's decision ceases to have effect pursuant to sections 32(5) and 32(6)(b) of the Act. We have also decided, pursuant to section 32(6)(c), to direct a number of discretionary conditions which shall have effect in respect of the regulated activity from the SB location. The conditions shall have effect until such a time as the Respondent considers it appropriate to remove them, under its own decision-making process.

39. The Tribunal accepted the oral and documentary evidence from Mr Mazengwa as to the impact the actions and failures of staff member 21 had on the service. The Respondent did not seek to contest this but made it clear that throughout staff member 21's time as the nominated individual, Mr Mazengwa remained the registered manager. This is a significant factor. The registered manager is responsible for ensuring there is regulatory compliance at all times at the service. The Tribunal found that Mr Mazengwa made a grave error of judgment in his role as a registered manager for a lengthy period of time and did not lead SB effectively at all. It was clear from Mr Mazengwa's oral evidence that he had simply taken staff member 21's word for it when it came to assurance that effective systems were in place to quality assure the work, staff were being trained and supervised effectively and safe and effective care was being delivered to service users, in their own homes, in a timely and safe manner. The Tribunal has no doubt that from May 2022 until at least April 2023, this was simply not the case. The Tribunal concluded that in 2022, when staff member 21 was in post as nominated individual, Mr Mazengwa failed in his duties as a registered manager. He did not implement an effective system for assuring himself, directly, in a similar manner to the inspection methodology used by the Respondent, that SB was fulfilling its regulatory requirements.

40. The Tribunal took into account that Mr Mazengwa was dealing with difficult personal circumstances, which meant that at the time when the first relevant inspection took place in July 2022, he was out of the country attending to a close family bereavement. Be that as it may, Mr Mazengwa should have given careful consideration to changing the registered manager to a suitable competent person who would be able to oversee quality assurance and provide effective leadership at SB. Mr Mazengwa failed in his role as a registered manager in 2022. This was quite clear by the point at which Birmingham City Council carried out its own compliance visit to SB and made a decision to end its contract with SB due to serious safeguarding incidents. When that occurred, it was not contested that Mr Mazengwa was aware of the outcome of Birmingham City Council's visit and the reasons for it. In the Tribunal's view, at that point, alarm bells should have been ringing for Mr Mazengwa and that he continued to rely upon the information he was receiving or to trust that robust assurance was in place at SB was highly concerning and demonstrated a lack of effective leadership at that time.

41. Next, the Tribunal considered carefully the position maintained by Mr Mazengwa throughout – that he considered that by the time of the third inspection, Mrs Wilkes and the inspector team had closed their minds to any improvements made and had adopted a partial and unfair approach to the inspection. The Tribunal did not find this to the case, based on its assessment of the documentary evidence and its assessment of the credibility of Mrs Wilkes, Mrs Clewley, Mrs Higgs and Miss Lyndon.

42. The Tribunal placed significant weight on the outcome of Birmingham City Council's visit to SB, which had taken place just a short space of time before the Respondent decided to send in its team of inspectors. The Tribunal accepted the unchallenged explanation for this – the Respondent had received information from Birmingham City Council that it was decommissioning its service arrangements with SB, having found widespread failures and made a large number of safeguarding referrals, as it could not be satisfied that service users were receiving safe care. The Respondent's reasons for carrying out an unannounced inspection in July 2022 were rooted firmly in its statutory obligations.

43. The Tribunal found the evidence from the Respondent's inspectors and decision maker to be credible, consistent and supportive of a position of professionalism and integrity. The Tribunal found no clear evidential basis for concluding, on any reason, that Mrs Wilkes, Mrs Clewley and Mrs Higgs took a partial or closed-minded approach to the task of inspecting SB on more than one occasion. Furthermore, to be clear, there was no ground gained and no coherent evidential basis for concluding that the Respondent's approach to inspection and decision-making was anything other than meticulous, impartial and with a focus on the statutory objective of the Respondent.

44. The Tribunal found that it was more likely than not that the state of the service at SB, as observed by Mrs Wilkes in July 2022, was one of disarray. Mr Mazengwa was not present at the location during the inspection process.

45. The Tribunal considered it relevant to take into account the oral evidence from Mrs Wilkes as to her approach to the use of the Respondent's section 64 powers (in the Health and Social Care Act 2008 - the power to compel a registered manager to provide information/documents/records or other items which are necessary or expedient to have for the purposes of any of the Respondent's regulatory functions). She tried to secure the information she required to complete the inspection in an accurate and timely manner. Not only that, but when she received no response whatsoever from Mr Mazengwa, she used her discretion to extend time, in the hope that he would respond and comply. In the Tribunal's view, these are not the actions of an inspector who was acting in a partial, unfair or close-minded manner – she was trying to ensure the registered manager complied, without the need to take forward any section 64 action.

46. Furthermore, the Tribunal considered that the analysis Mrs Wilkes undertook, particularly her analysis of the call monitoring system. This analysis

demonstrated a forensic approach, with an attention to detail. Mrs Wilkes did not undertake her work lightly and the Tribunal was impressed with the clarity, thoughtfulness and reasoned nature of her oral evidence. The reality was that Mrs Wilkes was faced with a challenging set of circumstances, dealing with a service provider who was unable to provide information on which she could confidently rely. Given that the Respondent requires assurance from the services it regulates, i.e. it requires the services to demonstrate, though documents and procedures, that is it doing what it says it is doing, Mrs Wilkes was faced with a difficult process in inspecting BS as the records retained did not marry up with what she was being told by staff member 21 (in July 2022) and Mr Mazengwa in December 2022 and August 2023.

Regulation 9(1): person centred care

47. Mr Mazengwa seemed to broadly accept that at the time of the inspection in July 2022, BS was in breach of the 2014 Regulations, but since that time, the breaches are no longer in place and sufficient improvements have been made to lead the Tribunal to conclude that it is no longer proportionate to vary the conditions in the manner proposed by the Respondent. As acknowledged by Miss Lyndon, in her oral evidence, the decision to vary the conditions to remove the location of SB is, in reality, a decision to cancel the regulated activity from that location.

48. The Tribunal carefully considered the evidence as to the apparent breaches of this Regulation at each of the three relevant inspections. The Tribunal bore in mind, at all times, that this is a domiciliary care service which was inspected remotely, in the sense that it was inspected at the office. This was not a case of the inspectors going out and shadowing the carers providing care in service users' homes. The reason this is significant is because it adds to the importance of assurance through the practices documented in the records retained by the service at its central office. The assurance also centres on the quality and effectiveness of leadership and governance provided to the remote carers, who are working away from the office. The Tribunal considered this highly relevant in its assessment of the practices of SB as the Tribunal endorsed the approach to assurance, which was used by the Respondent, namely, if there is no record of something having taken place or a decision being made and the rationale for it, the inference is that it has not happened. Similarly, if there is a record of something having been done a particular way, that is the starting point to assure (or give rise to cause for concern to) the Respondent of the culture amongst the caring staff.

49. At the time of the inspection in July 2022, Mrs Wilkes and the two other inspectors reviewed records which covered a fair sample of service users (19). It is notable that at the inspection, there was a lack of clarity as to the number of service users to whom care was being provided and the number of staff. In fact, it was accepted by Mr Mazengwa that the decision of Birmingham City Council to decommission SB was welcomed as SB had taken on too many service users and was unable to manage care effectively. Mr Mazengwa also acknowledged that he had placed too much trust in what he was being told by the nominated individual at that time, to the extent that Mr Mazengwa, as the

registered manager, was not conducting any quality assurance reviews to assure himself that SB was being run in a safe and effective way.

50. As examples of what was found by Mrs Wilkes during the inspection of July 2022, it was unclear as to what medication had been given to service users and whether they had taken the medication or not. As such, this meant that the next carer, coming to provide care, would not be sure as to what prescribed medications had been taken and what medications were due to be taken as a result. This was the position with a number of service users, whose medication administration records (MARs) over a period of days, as a snapshot, were unclear. The inference drawn by Mrs Wilkes was that the carers (and, in turn, the registered manager/management team) could not be assured from the MARs as to whether medications had been given or not.

51. The care plans were incomplete or lacking in detail. Risk assessments were incomplete or blank. There was no coherent and standard approach to record keeping. There was no detail as to prescribed creams, even though staff were recording that creams had been applied. Daily records demonstrated that staff were recording that prescribed medications had been given, but the MAR for the service user would not reflect that a prescribed medication had been given. There were examples of prescribed medications, which had to be given at certain times, being given late as calls were taking place later than they should have and the absence of risk assessments for medications which carried increased risk from bleeding.

52. The Tribunal finds there is clear evidence that at the point of each inspection, SB was in breach of this regulation.

Regulation 10(1): service users must be treated with dignity and respect

53. The Respondent took information directly from service users and their relatives, through the expert by experience, who spoke with 33 people in total. The trend from the feedback was that staff were not always caring and friendly, with examples of staff being rude and people feeling like they were being treated as objects. The inspectors reviewed the care plans and found limited information as to the preferences of service users. There was evidence from the discussions with service users and their relatives that staff did not always know how to use equipment properly, to ensure dignity and respect. One example related to a relative observing the care staff hoisting their mother onto the shower chair with part of her bottom positioned on the sling and part of it off the sling, which meant her skin could have been broken and the carers could have hurt their backs. There was limited evidence to assure the Respondent that staff were appropriately trained in using equipment to ensure dignity and respect and in wider ways of ensuring dignity and respect, such as with communication and respecting the preferences of people.

54. The Tribunal considered there was clear and compelling evidence, in the form of the cross-referencing and analysis which Mrs Wilkes completed in July 2022 in relation to call times. It demonstrated that calls to service users were late, too short and missed, which was not reflective of a caring and respectful

approach. There was evidence from discussions with service users that not knowing with confidence when their care would be provided caused anxiety. There was further evidence that some service users and relatives had not had any discussions with care staff to feed into their care planning. The Tribunal found that the service was in breach of Regulation 10 in July 2022.

Regulation 11(1): care and treatment of service users must only be provided with the consent of the relevant person

55. The practice of SB in relation to understanding capacity to consent to care and demonstrating the evidence relied upon to inform decisions relating to capacity to consent to care was lacking. There was no assurance that the service had secured the relevant documentation to support a conclusion that the service users in question lacked capacity and it was therefore appropriate for a family member to act on their behalf. There was no procedure around securing evidence to assure SB that the authority was in place for such an arrangement.

56. As demonstrated through the experts by experience, feedback established that service users and family members did not feel included in discussions about care or care planning. There was no evidence in the records that care planning was completed in consultation with the service users.

57. The Tribunal considers the service was in breach of this regulation in July 2022.

Regulation 12(1): care and treatment must be provided in a safe way for service users

58. As set out above, risk assessments were often not in place or they were not effective to meet the risks. As an example, more than one service user had been assessed by a speech and language therapist because there was a risk of choking. However, the care planning for the service users did not reflect the relevant information, such as modifications to diet – which would have allowed the carers to follow the care plans. It was not sufficient for the nominated individual to explain that family members were involved when there was no assurance in place that risk had been reviewed, care planning updated, and actions made clear for all care staff. Furthermore, there was evidence that service users required blood thinning medications and no care plans were in place to inform the increased risk from bleeding or actions to take if such an incident occurred.

59. Furthermore, the Respondent could not be assured, from the records, that medications had been safely administered as the prescribed times, not least as calls were often late. There was no assurance that staff were appropriately using infection control and prevention procedures with regards to the correct use and disposal of PPE. In the Tribunal's view, these failures were sufficiently serious to amount to a breach of Regulation 12 in July 2022.

Regulation 13(1): service users must be protected from abuse and improper treatment in accordance with this regulation

60. The very fact that the inspectors had to make a number of safeguarding referrals as a result of concerns uncovered during the inspection in July 2022 is, in and of itself, capable of amounting to a breach of Regulation 13. There were numerous examples of safeguarding issues being raised with the registered manager and a lack of appropriate action being taken to address the issues, to minimise the risk of repetition. For example, three thefts had been reported by services users, including theft of money. There was no evidence to demonstrate that steps had been taken to minimise the risk of such incidents happening. There was an allegation made by a service user of an assault, which had been reported to the police. There was no evidence of any reflective or mitigatory steps being taken to lower the risk of such an incident occurring for a vulnerable service user. The Tribunal had no doubt that at the point when the inspection took place in July 2022, SB was in breach of this regulation. On the service provider's own account, the service could not manage the number of service users it had contracted to provide services and did not have sufficient staff numbers to ensure calls were managed appropriately. As a result of this, there was no assurance that service users were being properly protected from abuse and improper treatment.

Regulation 16(1): any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation

61. This was a significant area for feedback from service users through the expert by experience process. Service users and family members relayed that they were not confident of their complaints being acknowledged, investigated and an outcome notified to them. There was no evidence provided by SB to demonstrate that it had logged complaints and completed investigations and taken forward learning and changes in its practices. There was a general lack of confidence in the system of raising complaints when carers ran late for calls, completed short calls or did not arrive for calls. There was no evidence of the service having a complaints process which was followed, from the point of record keeping through to outcome and learning. This was concerning, given the size of the service at the time of the inspection and in light of the safeguarding concerns raised by the inspection team, as well as the issues identified by Birmingham City Council in May 2022. The Tribunal considers the service was in breach of this regulation.

Regulation 17(1): systems or processes must be established and operated effectively to ensure compliance with the requirements of assessing, monitoring and improving the quality and safety of services

62. The Tribunal concluded that this was a significant breach on the part of SB. Good governance should be at the heart of any service providing care to service users, most of whom would be considered vulnerable. At the time in question, Mr Mazengwa, on his own account, had left the management of the service, including quality assurance and auditing to the nominated individual. He had been prepared to take the nominated individual's word at face value, without understanding his own regulatory responsibilities as the registered manager of the service. In the Tribunal's view, the registered manager is under a constant

duty to ensure the service is being run in accordance with the Regulations. Apparent audits had not identified any concerns with medication administration and record-keeping, despite the inspection team identifying issues with this. There was no evidence of a regular supervision system for carers and no evidence of effective management of risk, record-keeping, tackling of staff and call issues and learning from complaint investigations. Crucially, there was no evidence that the service had a planned, systematic approach to quality assurance, identifying, implementing and sustaining improvements.

63. In the Tribunal's view, the most serious aspect of the breach of this regulation was the fact that Mr Mazengwa, as the registered manager, did not probe the information he was given by the nominated individual and did not conduct his own assurance. This was a significant and serious failure on the part of Mr Mazengwa.

Regulation 18(1): sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the regulatory requirements

64. The Tribunal considered the cross-referencing and analysis of calls undertaken by Mrs Wilkes at the July 2022 inspection. This clearly demonstrated that SB was unable to staff the volume of service users it had taken on – to such an extent that there was evidence of call cramming and calls taking place over a much shorter period of time than expected. Mr Mazengwa explained that often times service users would simply say that they did not wish for the carer to stay for the allotted time. There were no records of this in any of the service users' records. This information would have acted as an assurance to the Respondent that an adequate explanation was contemporaneously recorded as to why a call had taken place over a shorter than contracted time period. In the absence of that information, the obvious inference is that the calls were not taking their full length of time because staff members were under pressure to move on to the next call. In turn, the Tribunal concluded that this was largely because there were not enough staff members fulfilling contracted hours to cover the volume of service users. It is not possible to accept another reasonable explanation in the absence of records and in the absence of definitive numbers on service users and staff members.

65. The Tribunal also took into account the response to the notice of proposal from Mr Mazengwa (dated 5 September 2022) which implicitly accepted that SB did not have sufficient numbers of staff to manage the care needs of its service users effectively, noting that "the size of the organization is also falling into a manageable entity as the organization had become too big before" and "this decommissioning exerciser will leave us with sizeable *[sic]* clients which is easy to manage with minimal risks to people".

Regulation 19(2): person employed must have the qualifications, competence, skills and experience which are necessary for the work to be performed by them

66. At the point of the inspection in July 2022, there was clear evidence that not all staff members had their disclosure and barring service (DBS) checks completed prior to commencing employment. Furthermore, there was no evidence to assure the Respondent that suitable references were always obtained for all staff members, along with exploration of gaps in employment history and a full employment history. This demonstrated that SB did not have a rigorous process in place for recruitment that ensured it could meet the requirement of Regulation 19. Accordingly, the Tribunal found that SB was in breach of this regulation at the material inspection times.

Regulation 20 (1): registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity

67. By the time of the second inspection, in December 2022 and January 2023, the Appellant was unable to provide full and open information to Mrs Wilkes. The Tribunal considered it serious to note that SB still could not provide an accurate number of service users to which it provided care and staff with which it contracted to provide the care. In the Tribunal's view, the reasons for this do not diminish the seriousness of the failures. It doesn't matter to the Tribunal that Mr Mazengwa was dealing with the immediate aftermath of terminating the services of staff member 21. To the Tribunal, the serious failure sat firmly with Mr Mazengwa – he simply did not have a handle on the service he was managing, to such an extent that he was unable to provide accurate information to assure the Respondent.

68. The Tribunal was struck by the oral evidence from Mrs Wilkes, an inspector with the Respondent since November 2019 and Miss Lyndon, an employee at the Respondent in a number of regulation roles, from 2004 onwards, that they had never before had to use section 64 of the Act to compel a registered manager to provide information, with the consequence of a fine, if convicted of the offence. Irrespective of Mr Mazengwa's explanation for what was going on at the time, or the fact that he started to draft an email to send in response, albeit after the deadlines set by the Respondent, the Tribunal concluded that the failure to provide the requested information by the set deadlines constitutes a breach of Regulation 20. Furthermore, the Tribunal concluded it was a serious breach, given that the Respondent had to effectively threaten further action in an effort to elicit a response, which when it came, was late and incomplete. This is unacceptable from any registered manager, and it amounts to a failure to be open and transparent.

69. As to the overall rating of inadequate, which was first given to the service as a result of the extent of breaches of the Regulations, a rating of inadequate was, in the Tribunal's view, entirely justified at the point of inspection in July 2022. The Tribunal considered the documentary evidence and the oral evidence from Mrs Wilkes and Miss Lyndon, in particular. The decision to impose a condition that SB no longer provide the regulated activity from its location was a reasonable and proportionate decision at the point when it was made in September 2022. The Tribunal concluded that at that point, when the service provider could not provide clarity on the number of service users to which it

provided care and the registered manager could not provide assurance that he understood the nature and extent of the problems as the service provider, the Respondent had no choice but to vary the conditions of registration to effectively close the SB location.

Remaining grounds

70. At each relevant inspection, a sample of the records from service users was reviewed by the inspectors, a sample of staff provided input to the inspectors and an expert by experience contacted service users and their relatives to seek feedback. The Tribunal considered the sample to be wide enough and the sources of information diverse enough to mean that the findings of the inspectors were made on a sufficiently robust review of the quality of care provided by SB. The Tribunal does not accept the ground of appeal from Mr Mazengwa that the Respondent had closed its mind to any improvements or to any other rating than 'inadequate'.

71. By the time of the second relevant inspection, which was announced and took place between December 2022 and January 2023, it was a serious failure on the part of Mr Mazengwa that he was unable to provide an accurate figure for the number of service users and he had not provided open and accurate information to the inspectors. Mr Mazengwa initially explained that the service provided care to 12 service users. A different system was being used to record the care provided for an additional 88 service users. Mr Mazengwa had to be made the subject of a section 64 request from the Respondent in order to gain clarity as to the number of service users and the fact that different care planning systems were being used to coordinate care centrally. The service provider had not demonstrated the required level of sustained improvement in order to give the Respondent any other option that to continue to rate the service as inadequate, on the basis that Regulations 9, 10, 11, 12, 13, 16, 17, 18, 19 and now 20 were breached. On Mr Mazengwa's own explanation, in oral evidence, the service was not in the position he wished it to be in at the point of the second inspection. He was still unable to provide clear information as to the number of service users to which SB was providing care. The system of oversight and supervision was lacking, and the Respondent could not be confident that service users were receiving safe, effective and competent care. The further input through the expert by experience did not give any confidence that there had been an improvement in the quality of care. It was significant that the nominated individual (staff member 21) had finished employment at SB on 8 December 2022 and Mr Mazengwa had made the decision not to engage the services of an external consultant until he managed to make some improvements of his own accord. This was his explanation as to why it took until April 2023 to engage the services of Mr Fairman to lead on improvements and compliance. The Tribunal found this explanation reasonable, in light of the fact that Mr Mazengwa wished to consider the outcome of the inspection, through the published inspection report (published on 15 March 2023) and use the findings to inform the work of Mr Fairman.

72. The Tribunal noted the oral evidence from Mr Fairman. He did not consider the service to have been at a rating higher than 'inadequate' at the point when it

was inspected in August 2023. The Tribunal considered it relevant to note that Mr Pindani had attended SB the weekend before the announced inspection in order to prepare documentation for the inspectors as it was not in a form which would have been accessible for the inspectors. At that stage, it was just over one year from when the service had been placed in special measures as a result of its inadequate rating.

73. The Tribunal found Mr Fairman to be a fair, reasonable and credible witness, with a level of experience in the care industry, working as a consultant. At the present time, he is performing a compliance officer role. He has been assisting Mr Mazengwa to improve the service since he was first engaged in April 2023. Mr Mazengwa was also a largely credible witness. The Tribunal formed the view that Mr Mazengwa is now committed to making effective improvements to the service. He has not sought to take on more service users and is now operating at a level of almost one carer to one service user. The Tribunal placed weight on the opinion of Mr Fairman, who has worked with Mr Mazengwa for longer than Mr Pindani. Mr Fairman was of the view that if SB was reinspected, as at the date of the hearing, it would be likely to receive an overall rating of 'requires improvement'. He was realistic in his assessment, based on his work with SB. He did not consider the service would be able to move from 'inadequate' to 'good'; it would require more sustained work to quality assure, lead the office-based team in gaining further confidence with the high standards expected by Mr Mazengwa and to ensure the team of carers were implementing the change in compliance and oversight of risk which he had brought to SB, in conjunction with Mr Mazengwa.

74. The Tribunal placed limited weight on the two reports from Mr Pindani – from September 2023 and February 2024. He did not provide a witness statement, with a statement of truth and did not attend the hearing to provide oral evidence.

75. The Tribunal concluded, through his oral evidence, which was tested at length by Mr Misra, that Mr Mazengwa demonstrated a commitment to compliance with the fundamental standards of safe and effective care. He had no plans to take on additional service users at the present time and he planned to continue to use Mr Fairman's expertise to ensure compliance with the 2014 Regulations, with improvements embedded across the service provider.

76. The Tribunal concluded that Mr Mazengwa has managed to make a number of improvements to the service provider since October 2023. Mr Fairman observed that the staff have demonstrated a commitment to improve and have shared changes they have made with him on each visit to the service. The Tribunal took into account the significant stress that Mr Mazengwa was likely to be under at the point of the second inspection, following the challenges of the breakdown in his relationship with staff member 21 and the substantial breaches of the Regulations which were identified. The Tribunal accepted as reasonable his explanation as to why he engaged the services of Mr Fairman from April 2023 onwards. It is not surprising, in the Tribunal's view, that limited progress had been made by the point of the inspection in August 2023. The Tribunal is in no way critical of the approach from the Respondent. The Tribunal accepts that it has valuable resources which have to be used efficiently and it

had anticipated that the hearing would proceed in October 2023. The Tribunal does not consider it unreasonable or indeed unfair that the Respondent decided not the conduct a fourth inspection in preparation for the hearing at the end of February 2024. However, the Tribunal must make the decision afresh as at the point of the hearing, where it had the benefit of credible and committed oral evidence, over the course of one day, from Mr Mazengwa and from Mr Fairman. What was clear to the Tribunal was that Mr Mazengwa had made a number of improvements to the service's leadership, governance and the quality of its work since the most recent inspection.

77. The Tribunal considered if the current conditions, decided upon by the Respondent in September 2022 remained fair, reasonable and proportionate as at the date of the hearing. As part of this decision-making process, the Tribunal bore in mind that to dismiss the appeal and allow the conditions to take effect would mean the closure of SB. The Tribunal also considered the changes implemented by Mr Mazengwa, working closely with Mr Fairman is what is effectively a compliance officer role. We balanced the risk of harm to service users against the commitment which Mr Mazengwa now shows to the service. The Tribunal considered if there were other conditions which could address the ongoing concerns about the service, including risk of harm, with a view to a further inspection to test Mr Fairman and Mr Mazengwa's firmly held views that SB has improved to such an extent as it will no longer have an overall rating of 'inadequate'. Mr Mazengwa should understand that if SB receives an overall rating of 'inadequate' at its next inspection, it is highly likely that a decision to remove the location from the registration of Sentricare Ltd will be made and it will be difficult to see how an appeal against such a decision would succeed, given that SB's full regulatory history, including this decision, would be of relevance to the proportionality of a decision on a second appeal of this kind.

78. The Tribunal has concluded, on balance, that the condition to remove Sentricare Birmingham as a location from which the regulated activity of personal care is provided is no longer proportionate. The Tribunal has decided to direct that the Respondent's decision ceases to have effect pursuant to sections 32(5) and 32(6)(b) of the Act. We have also decided, pursuant to section 32(6)(c), to direct a number of discretionary conditions which shall have effect in respect of the regulated activity from the Sentricare Birmingham location. They are set out below. We make it clear that the decision as to when it is appropriate to review and vary such conditions will be a matter for the Respondent, in line with its continuous statutory duties.

Order

It is ordered that:

1. The appeal is allowed.

2. The Respondent's decision of 28 September 2022 shall cease to have effect, pursuant to sections 32(3) and 32(6)(b) of the Health and Social Care Act 2008.

3. The following conditions are now imposed on Sentricare Ltd's registration,

pursuant to section 32(6)(c) of the Health and Social Care Act 2008.

(a) The registered manager at Sentricare Birmingham shall provide the CQC with a report on the first working day of each month setting out the outcomes of its quality assurance audits, with effect from 1 May 2024.

(b)At the same time, the registered manager must also provide a report on progress against its continuous improvement plan, which must include details on the work of a compliance officer, or similar role at Sentricare Birmingham, with effect from 1 May 2024; and

(b) Sentricare Birmingham shall not provide the regulated activity of ‘personal care’ to any new service users, which includes taking on new service users to replace those who no longer require the services of Sentricare Birmingham.

Judge S Brownlee
Care Standards & Primary Health Lists Tribunal

First-tier Tribunal (Health, Education and Social Care)

Date issued: 26 March 2024