First-tier Tribunal Care Standards

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

[2023] 4935.EA
Neutral Citation Number: [2025] UKFTT 00324 (HESC)

Heard on 11-14 November 2024 at
The Birmingham Civil and Family Justice Centre

BEFORE
Tribunal Judge – Ms S Iman
Specialist Member – Dr D Cochran
Specialist Member – Mrs L Jacobs

BETWEEN:-

Holistic Health Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. This is an appeal of Holistic Health Limited ("the Appellant") against the Care Quality Commission ("the Respondent") decision to refuse to vary the company's registration. The Appellant is a registered service provider in respect of the regulated activity of 'transport services, triage and medical advice provided remotely' (Activity) and currently carries out the Activity from Suite 12, Anchor House, Anchor Business Park, New Road, Dudley, DY2 9AF.

2. The hearing took place on 11-14 November over 4 days. The parties and their witnesses attended in person at The Birmingham Family and Civil Justice Centre. The Tribunal met remotely for deliberations on 20 January 2025 following receipt of written submissions from both parties.

The Hearing

3. The Tribunal were alert to the fact that Mr Ayokosok was not represented and therefore reasonable adjustments were made to assist him during the hearing. The Tribunal also assisted Mr Ayokosok in clarifying his questions to the witnesses throughout proceedings. Throughout the hearing the Tribunal ensured that adequate breaks were given throughout the day. The Tribunal also requested written submissions from the parties due to Mr Ayokosok giving evidence prior to the close of proceedings and the Tribunal wanted to ensure that he was given adequate time to prepare his written submissions. Mr Ayokosok also expressed a view to the Tribunal that he would prefer submissions to be in writing and required 2 weeks for them which we were happy to accommodate. It was also brought to our attention that he had a disability of visual impairment when reading which meant that he may require further time to read documents.

Attendance

4. Mr Ayokosok attended in his capacity as Director and owner for Holistic Health Limited and represented himself. Mr Harrison represented the Respondent. Ms Monteith (Regulatory Inspector) attended as witness for the Respondent in these proceedings.

5. The witness statements of Ms Ward were admitted and read into the record.

Late Evidence

6. The Tribunal received the Scott schedule in advance of the hearing. We also received the Appellant's Skeleton Argument and the Respondent's Skeleton Argument.

7. The Tribunal also received the following late evidence. These documents were as follows;
   a) The Cromer Report submitted by the Appellant
   b) Updated supplementary bundle containing applications from parties regarding strike out and/or stay of proceedings.

8. There was an objection from Mr Ayokosak regarding the witness statement of Miss Ward (see below) regarding the late evidence and proceeding with the updated supplementary bundle. The Respondent did not object to the admission of the Cromer report. In respect of the supplementary bundle both parties accepted that the documentation contained within it had been seen previously and had been updated to assist the Tribunal (see paragraph 24 below). It appeared to the Tribunal to be necessary to the proper determination of the appeal to admit these documents and was not prejudicial to either party. The Tribunal admitted the above evidence pursuant to Rule 2 and Rule 15 of the First Tier Tribunal (Health, Education and Social Care Chamber 2008) Rules as the evidence was relevant to the issues for determination and it was in the interests of justice to do so.

9. Following the hearing, the Tribunal received final written submissions from both the Appellant and the Respondent.

Background

10. The Appellant was registered with the Respondent as a Registered Service Provider on 1 September 2021. It is registered in respect of the regulated activities from the location at Suite 12, Anchor House, Anchor Business Park, New Road, Dudley, DY2 9AF (the existing location"). This registration is subject to the following conditions:-

    The registered provider must ensure that the regulated activity Transport services, triage and medical advice provided remotely is managed by an individual who is registered as a manager in respect of that activity at or from all locations.
    This Regulated Activity may only be carried on at or from the following locations: Holistic Health, New Road, Dudley, DY2 9AF.

11. In response to the application the Respondent carried out a site visit on the 20 December 2022. At the site visit the Respondent found the Appellant to be in breach of three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

12. The Decision is to refuse the application to vary the conditions of the Appellant's registration as a service provider in respect of the regulated activity at or from the Proposed Location. The Decision was made by the Respondent for reason of breaches of standards of care as set out in the 2014 Regulations. The Appellant was given reasons for the Decision.

13. The following summary was given with respect of the Decision:
    "… the Commission was not satisfied that the requirements of the Regulations are being and will continue to be complied with (so far as applicable) in relation to the carrying on of the regulated activity, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulations') … Your representations and documents provided have been read and fully considered. You have not demonstrated that all the Commission's concerns have been addressed and that you are able to carry on the regulated activity in accordance with the relevant requirements ...".

    Regulation 12:Safe Care and Treatment
    Regulation 13: Safeguarding Service Users from Abuse and Improper treatment
    Regulation 15: Premises and Equipment

14. On the 25 January 2023; the Respondent served the Appellant with a Notice of Proposal together with evidence. The Appellant provided written representations to this NOP on the 12, 21 and 22 February 2023. On the 03 March the Respondent served the Appellant with a Notice of Decision. This is an appeal of that decision.

Preliminary Issues

15. The following issues were considered by the Tribunal prior to the substantive hearing;

The Respondent's application for strike out
The Appellant's application for strike out.
The admissibility of evidence including that relating to the site visit on 19 July 2023.
Adjournment request/ stay of proceedings which related to the non attendance of Ms Ward

16. **The Respondent made an application for the Appellants case to be struck out without further order in accordance with rule 8 (3) c of the Tribunal Rules** We were provided with a comprehensive document setting out their reasons for the application which will not be rehearsed here. The Application was made on the basis that none of the documents submitted by the Appellant demonstrated that the Appellant had likely grounds of success in the appeal and that no evidence had been provided that demonstrated that the Appellant was longer in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 nor was it meaningful documentation and there had been no compliance with the Orders in a helpful way.

17. The Tribunal reminded itself of the relevant Rules

    8(3) The Tribunal may strike out the whole or a part of the proceedings if—
    (a)the appellant has failed to comply with a direction which stated that failure by the appellant to comply with the direction could lead to the striking out of the proceedings or part of them;

    (b)the appellant has failed to co-operate with the Tribunal to such an extent that the Tribunal cannot deal with the proceedings fairly and justly; or
    (c)the Tribunal considers there is no reasonable prospect of the appellant's case, or part of it, succeeding.

18. The Tribunal considered that the strike out application itself would require an assessment of the documents and given the parties had attended we did not consider it was in the interests of justice to allow the application.

19. **The Appellant's application to stay proceedings and have the Respondent's case struck out on the basis of non- compliance and conduct grounds 15 October 2024 and appeal of Order on 09 October**. We were advised that the Appellant's application to strike out the claim was made on the 30 September 2024. Further that there was an appeal of the Order dated the 9 October which was submitted on the 15 October 2024. The Tribunal was provided with written representations from both parties which will not be rehearsed here. In essence the application for strike out was made on the basis of delay in receiving documents.

20. The Tribunal ordered on the 09 October that the CQC must provide the bundles to the Appellant on 11 October 2024 and confirmation of receipt was provided by the courier company. The Respondent requested confirmation of receipt of documents on 11, 14 and 20 October 2024 from the Appellant and the Appellant provided confirmation on the 21 October.

21. We accepted that the electronic documents had been adequately served and that Mr Ayokosak had been served with the hard copy documents a short while later. Further the Tribunals understanding was that Mr Ayokosak added a ground for stay proceedings that the non- attendance of Marie Ward should be an additional reason for strike out. The short delay in respect of serving the bundle on the 27 September 2024 was dealt with at the 09 October hearing and did not need to be re ventilated before this Tribunal. However, for completeness we did not consider that there had been any error in the way it had been dealt with at the 09 October hearing.

22. Nor did we consider that there was any merit to the assertion that the Tribunal was biased in any way on that occasion and rewarded the Respondent or that the Tribunal should have struck out the matter for contempt of court as argued by Mr Ayokosak.

23. Mr Ayokosok explained that there were numerous new elements to the case and there was an entirely new case and he needed time to prepare. We did not consider there was any merit to this argument nor there was any deliberate misleading by the Respondent. Therefore we did not stay the proceedings or set aside the 09 October Order.

24. Though Mr Ayokosok stated that the Respondent did not deliberately provide bundles and that it was impossible for him to defend himself. He also during submissions requested that the hearing be adjourned as he had not had sight of what was in the updated supplementary bundle. He also later in his submissions acknowledged that the evidence in the bundles had been previously sent to him and that he was familiar with the documents in the supplementary bundle. The Tribunal therefore did not adjourn proceedings and afforded Mr Ayokosak the time to read through the supplementary bundle which was not extensive.

25. We were not persuaded that the Respondent had acted in anyway to render the hearing unfair so that the proceedings could not be dealt with fairly and justly nor do we consider that there is no realistic prospect of success for the Respondent or the Appellant at this stage.

26. We did not consider that there was any deliberate non compliance or there was any unfairness in the proceedings by the Respondent at the case management hearing on 09 October. We accepted that Mr Ayokosak had an opportunity to respond, including the ability to respond to the out of office message he received and he chose not to for reasons best known to him. It became apparent that Mr Ayokosak will rely on the documentation in the bundle which he submitted some time ago. We are clearly experienced with those self-representing and we can make adjustments required but the applications to adjourn and strike out proceedings was refused.

27. One of the new elements of the case Mr Ayokosak explained was the need to request a witness statement from the delivery driver regarding the bundle. We did not consider that this would be something that would assist us in our determination of the case. We were not persuaded that there were new elements to the case.

28. Considering then the Appellant's Application dated 30 September we considered that any issues with the site visit and actions of 19 July could be properly dealt with in cross examination and did not require us to adjourn. We also took into account that all the Respondent's evidence had been served in November 2023

29. The Second ground submitted for application to strike out was in respect of the Respondent's failure to respond to the rest of the incompetencies pointed out. The Tribunal reminded itself that it is here to determine the issues namely that the decision made by the CQC was proportionate and necessary and any incompetencies could be raised by the Appellant during the hearing.

30. **The Appellant's Application to stay proceedings dated 26 October.** This application was made as the Appellant was requesting a stay in proceedings for the Respondent to submit documentation such as proof that Marie Ward was unavailable. The Respondent was clear in the submissions to the Tribunal regarding Miss Ward and as Mr Harris was an officer of the court we did not consider that we required any further evidence that required an adjournment of proceedings. We heard detailed submissions from both parties. We have considered the reasons given for Ms Ward's non attendance carefully.

31. Ms Ward, Inspector provided a witness statement on behalf of the Respondent dated November 2024. Marie Ward has left the Employment of the Care Quality Commission and the Tribunal heard that she left for health reasons. Further that she was now self employed and any attendance would have financial impact on her which may cause additional concern to her Though we accept that Ms Ward attended both inspections we also note that we have the evidence of Ms Monteith who will giving evidence about the July inspection and was involved in Management Review Meeting which involves the inspectors meeting. We have carefully considered that Care Quality Commission have made reference to health factors that caused her to leave employment and therefore we consider that it would not be appropriate to compel her to attend and that the parties would be able to make submissions to the Tribunal in respect of the weight that should be attached to her witness statement. We consider that her evidence therefore can be read.

32. **Inadmissibility of the evidence**

33. The submission that all the evidence from the inspection that occurred in July is inadmissible is rejected. It is clear that was notice given to the Appellant regarding the inspection and that this was consented to. The CQC have a role to ensure that conditions are varied in accordance to public safety and any inadequacies of the site visit can be put to Ms Monteith. Mr Ayokosak participated in the inspection and has numerous opportunities to send evidence to this tribunal.

Restricted Reporting Order

34. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or

matter likely to lead members of the public to identify the service users in this case, so as to protect confidentiality and privacy.

35. Consistent with this, the names of service users and their family members and some other details have been anonymised in this decision.

Issues

36. Pursuant to directions the overarching issue was identified by the parties to be whether the CQC was correct in its decision of to refuse Holistic Health's application to vary a condition of the registration.

37. Has the appellant demonstrated that its application would comply with the relevant statutory guidance issued pursuant to;

    a) In respect of Regulation 12 whether there is an established system that results in cleaning being completed on a consistent and ongoing basis and provides scope for an effective scheme of oversight.
    b) Whether systems for administering oxygen are maintained to a safe standard.
    c) The circumstances in which oxygen would be provided to service users and whether staff are suitably qualified and/or competent to administer oxygen.

38. Whether risk assessments have been carried out by a suitably qualified person, and are subject to review and updates as appropriate.

39. In respect of Regulation 15, the following are the matters in issue:
    a) Whether there are systems in place to ensure that vehicles and equipment are adequately maintained.
    b) Whether damage to property is promptly identified and whether repairs are undertaken in a timely manner.
    c) Whether there is a process to ensure that life-saving equipment is checked by a suitably qualified person.

40. In respect of Regulation 13, the following are the matters in issue:
    a) Whether the safeguarding provision is adequate at all times and not reliant upon Mr Ayokosok.

41. Whether the Care Quality Commission had undertaken a "raid" as opposed to an inspection during a site visit in July.

Legal Framework

42. The main objective of the Respondent, by virtue of s.3(1) of the Act, is to protect and promote the health, safety and welfare of the people who use health and social care services. Pursuant to s.4 of the Act, the Respondent must have regard to various matters, and it must ensure that any action taken is proportionate and necessary.

43. By s.12(5)(a) of the Act, the Respondent has the power to at any time vary or remove any condition for the time being in force in relation to a person's

registration as a service provider. This power extends to a refusal to vary or add a condition as sought in an application made pursuant to s.19(1)(a) of the Act.

44. The Appellant is provided a right of appeal to the Tribunal by s.32 of the Act: The Appellant may appeal against a decision to refuse to vary the conditions of the registration of a service providing a regulated activity.

45. The Tribunal may confirm the decision(s) taken by the Respondent or direct that the decision(s) not have effect. In effect, the Tribunal can vary, cancel or impose any condition(s) on the registration that it sees fit.

46. The Appellant bears the burden of persuading the Tribunal that the decision to refuse to vary the conditions of registration was wrong. In practical terms, the Appellant must demonstrate that the Proposed Location is a suitable location from which the Activity may be carried out in compliance with the 2014 Regulations.

47. We are required to determine the matter de novo and make our own decision on the merits and on the evidence as at today's date. Subject to relevance and fairness, this can include new information or material that was not available (or presented) when the decisions under appeal were made. The appellant bears the burden of persuading us that the variation to the existing registration should be granted.

The Witnesses

48. Each witness adopted his or her statement (s), (where his/her background and experience were set out in far more detail), gave further evidence and was cross examined.

Tribunal Reasons

49. We found Ms Monteith to be a reliable, balanced and fair witness. She made concessions where appropriate. We considered that Mr Ayokosak was unreliable in his evidence, changeable, and evasive. We considered that he lacked a fundamental understanding of the role of the CQC and how to engage with them, in that he repeatedly requested evidence from the CQC regarding their guidance e.g. regarding sluice facilities which he described as ritualistic assumptions as opposed to focussing on providing cogent evidence to demonstrate that he would be able to meet regulatory requirements. He maintained in his closing submissions that the CQC *based their reason for refusal on ritualistic assumptions and opinions.* We gave weight to Miss Ward's statement where it was corroborated with other written and/or oral evidence.

Regulation 12

Cleaning System

50. The Tribunal were not satisfied that there was any cogent evidence presented to demonstrate that there is an established system of cleaning that is being

adhered to at the Proposed Location. The Appellant provided the following documents:

a) An document titled 'Patient Transport Service Cleaning Schedule' ;
b) A certificate indicating that staff received Level 1 and 2 Infection Prevention Control training;
c) The 'Infection Prevention and Control Policy and Procedures' issued on 21 April 2021, to be reviewed in April 2022;
d) A policy document titled 'Deep cleaning guidance in Care/Ambulance'; and
e) An excerpt from a document that appears to be a risk assessment in respect of cleaning activities.

51. The Tribunal have had careful regard to these documents and the oral evidence that we heard. We accepted Mrs Monteith's evidence that the cleaning schedule simply outlines tasks to be completed and that there was no place for the relevant staff member to indicate what cleaning has been carried out, nor is there room for comment (i.e., if there was damage to a piece of equipment). There was no clear reference to a member of staff having oversight to ensure that cleaning was concluded satisfactorily.

52. We were satisfied that the certificate suggested that five members of staff were provided in- person training on 15 subject areas on one day and this raised concerns about the quality and depth of the training delivered. We were not provided with any evidence of ongoing assessment of the competency of the staff and whether the learning from this training had been put into practice.

53. This document was 2 years old and referred to the fact that "cleaning must be carried out according to company cleaning schedules and logs", however we were not provided with any documents that purported to report the company cleaning schedules. Though the document indicated deep cleaning every six weeks Mr Ayokosok was unable to explain why and how that time period had been selected and more importantly how there was effective oversight of the schedules.

54. We accepted the evidence on Ms Monteith the deep cleaning guidance refers to the use of a colour-coding system, but this is not actually utilised at the proposed site and we accepted that the guidance as to when deep cleaning should take place, i.e., when it is "visibly too dirty" may result in cleaning not taking place when necessary.

55. We accepted that it was unclear when the "risk assessment" was written and whether it is operative given the multiple dates contained within it. It was not explained to us why disposable mopheads are used for a period of three weeks. Mr Ayokosok stated in his evidence that this was guidance from the manufacturer, but such guidance was not provided to us. We agreed with the Respondents that these documents had limitations and that they invite subjectivity into the assessment and standard of when cleaning should take place. The documents identified the issue of the lack of sluice facilities, which

was identified on 19 July 2023. We were not provided with a satisfactory rationale as to why issues with sluice facilities had not been identified earlier.

56. The issues that the Respondent identified with cleanliness on the site visits do support the Respondents conclusion that the systems in place are inadequate. The lack of robust systems makes it difficult for there to be adequate oversight and the Tribunal cannot be assured that cleaning will be consistently carried out to an adequate standard. The consequences of failure to clean adequately create an infection risk for vulnerable service users.

57. The issues in respect of cleaning were not identified nor challenged in either of the Croner reports and any later evidence. The Tribunal did attach limited weight to the report as we had regard to the fact that cleaning was not considered in the 2023 report save in respect of flooring, and was only considered superficially in the 2024 report namely "Housekeeping was to an acceptable standard on the day of the visit" and the assessment of the author that infection control policy and procedure is "not a significant issue" given the nature of the activities at the Proposed Location was very limited.

58. We accepted that the report itself was very brief, there was no information provided as to the methodology used by the author. There were wider issues with the report namely that in 2023 issues with fire extinguishers were not commented upon in the report and there was no additional evidence submitted with the report so the Tribunal could not be clear as to what documents were reviewed or relied upon.

Oxygen Storage and equipment

59. The Tribunal were not satisfied with the documents provided by the Appellant in respect of oxygen storage. In the 'Medicines Management Policy and Procedures' it stated: "Holistic Health Limited will not store its own supplies of medication". The Appellant has also submitted a document titled 'Care – Storage of Medical Gases', where guidance was given in respect of the storage of medical gases.

60. The Appellant told the Tribunal that the current position is that oxygen should be stored in a specific room at the site. No documentary evidence was submitted in respect of this.

61. The information provided on 19 July 2023 to the CQC indicated that oxygen was stored overnight on a vehicle. No risk assessments reflected the additional dangers associated with storage of gases in a vehicle overnight. The Respondent also concluded that on 19 July 2023 there was an inadequacy of signage – both in the building and on the vehicles – which would warn of the storage of potentially dangerous gases which the Tribunal accepted.

62. In oral evidence, Mr Ayokosok described a process by which a third-party company would attend the site and replace oxygen cylinders. No evidence of the details of this arrangement has been provided. Mr Ayokosak also explained that no evidence was provided by the CQC that oxygen should be

mentioned in a medication policy. This was a theme in Mr Ayokosak's evidence that he expected the CQC to provide evidence to substantiate their requests.

63. The Appellant also failed to provide adequate assurances that a suitably accredited person assessed the oxygen equipment on site. The certificate relied upon by the Appellant did not explain the training of the assessor it generally referred to inspection and service of "… oxygen system, and other service devices." We accepted and considered that this was inadequate. In addition, the document explained that stickers were applied to the tested equipment, but these were not visible on 20 December 2022.

64. The Appellant's explanation for this was that the intensity of cleaning may have removed them – but we did not find this persuasive. Given the serious harm that could occur if oxygen systems are inadequately maintained, we accepted that the document was insufficiently detailed to demonstrate that the systems are safe. On 19 July 2023, it was noted that there were not enough oxygen regulators available. The Appellant sought to persuade the Tribunal that this does not present a risk because it would not accept a job where oxygen may need to be provided unless a regulator was available. We considered that this was unsatisfactory.

65. However, where a service user required oxygen for the first time, no regulator would have been sought prior to the job and there was a possibility that an ambulance could start a journey with oxygen but no regulator. The Tribunal was not satisfied that the Appellant was aware of the risks associated with storage of oxygen and maintenance of related systems nor that it has done enough to mitigate those risks.

Oxygen administration

66. In the evidence before us we were told that the Appellant will provide oxygen to service users if directed following a call to the emergency services (on either 111 or 999), or if a patient with their own oxygen supply should need to change supply during a journey.

67. Therefore, we accepted that there remained a possibility that the Appellant may need to provide oxygen in unexpected circumstances such that it would not be possible to pre-plan which members of staff would be required to do so. In those circumstances, we accepted the Respondent's position that training in the safe administration of oxygen should be mandatory for staff travelling with service users. The Appellant did not treat oxygen administration training as mandatory and we were not persuaded that he had evidenced the rationale behind this decision.

68. In respect of the provision of oxygen to service users with their own oxygen supply that runs out, this was not referred to in any policy document provided by the Appellant. Therefore, there we could not be assured that there was a process that should be followed nor what risks have been identified and addressed by the Appellant.

69. In respect of the provision of oxygen in an emergency situation, the Appellant stated that the applicable policy is the 'Care of the Deteriorating Patient Policy and Procedures'. There was no reference to oxygen in this document. There is reference to emergency services, and the Appellant would administer oxygen if advised to do so by a call handler We accepted that that this creates a serious risk of unsafe provision of oxygen. We accepted the Respondents conclusions that these issues were compounded by the poor and inconsistent maintenance of systems to administer oxygen, which could result in oxygen supply being intermittent or faulty.

Risk Assessments

70. We agreed that the Appellant has not provided evidence that the individual preparing, the fire risk assessment had appropriate qualifications or experience. We were not provided with a fire risk assessment therefore it was unclear what risks have been identified generally and what control measures have been put in place.

71. The legionella risk assessment, in the original document, the Appellant outlined that a control measure was "Hot water taps are fed from instantaneous heaters or local volume water heaters set at 50 °C or greater. The Respondent observed that the relevant consideration must be the temperature of the water and that there is potential for error if, for example, the water heaters were set at 50ºC, but the actual water temperature was lower. It was recommended at the inspection to the Appellant that the risk assessment be corrected to this extent. No change was made to the risk assessment.

72. The failure by the Appellant to acknowledge an issue with its risk assessment and follow the CQC recommendations. caused the Tribunal great concern The Tribunal were also concerned with the way that Mr Ayokosok gave evidence on this point.

73. Mr Ayokosok stated that the temperature of the water is of secondary importance – a few degrees either side "does not make a difference" – to the issue of water droplets and the need to avoid standing water. The issue of water droplets was not clearly identified in the risk assessment.

74. We did not consider that the Appellant had an adequate system of risk assessment in place. We accepted that there is no evidence that issues are being identified and addressed ahead of time.

75. The Tribunal concluded that the systems in place are inadequate and was not assured that the Appellant was capable of providing a service complaint with Regulation 12.

Regulation 15

Equipment Maintenance and Repairs

76. We agreed that the Appellant has been unable to provide up to date logs to show that equipment checks have been carried out. The Appellant explained

that stickers and labels have become dislodged from fire extinguishers due to the intensity of cleaning carried out at the site yet there were no documents provided to support this either before or following the inspection.

77. Mr Ayokosok gave evidence that the issues noted by the Respondent's inspectors at each of the site visit was damage that had occurred due to wear and tear and had simply not been identified in the short time since the previous check(s) carried out by the Appellant's staff. We did not find this explanation credible.
78. On 20 December 2022, the inspectors noticed that the tear on the chair in the ambulance had already been partly repaired by tape. There was no evidence provided of future, more permanent repairs, nor how this issue was being addressed.

79. On 24 February 2023, PTS Compliance identified that three fire extinguishers were faulty, those were not identified during the Croner inspection. Issues in respect of the fire extinguishers persisted on 19 July 2023 In evidence, Mr Ayokosok stated that, the broken fire extinguishers were kept on site in February 2023, and that the ones replaced in July 2023 were different. We did not find this a to be a plausible explanation.

80. The Tribunal took into account the number of issues identified – such as the damage to light fittings, exposed wiring, issues with signage, the tear to the chair, the straps on the stretcher, and the faulty fire extinguishers – we accepted that this made it unlikely that they were damaged in the very short time between the previous daily clean and the site visit conducted by the Respondent. There was no evidence provided by the Appellant to demonstrate oversight of equipment maintenance and ensure any issues or broken equipment are identified and repaired in a timely manner.

81. Therefore, the Tribunal was not persuaded that systems were in place to ensure that equipment would be maintained or repaired to good working standard.

82. Specialist equipment used by the Appellant included defibrillators. No cogent evidence was provided that a suitably qualified individual was contracted to check the equipment and ensure that it is appropriately calibrated.

83. The Tribunal concluded that Appellant does not have adequate systems in place to ensure that the equipment at the Proposed Location will be maintained to good working order. We accepted that there was an absence of evidence of oversight by Mr Ayokosok.

Regulation 14

84. Ms Monteith explained that there is now adequate signage in the vehicles and the staff have the minimum expected level of training. However, she raised her concerns arising from the issue of safeguarding of general application:

85. She explained that there is an argument that best practice is that all staff should be trained to Level 3 safeguarding because all staff "could potentially contribute to assessing, planning, intervening and/ or evaluating the needs of a child or young person".

86. It was accepted that there was only one Level 3 member of staff, which may lead to inappropriate oversight or protections when that individual is away or unwell. However, Miss Monteith in her evidence accepted that other settings would only train to level 2 and that this was a matter for debate and therefore we did not consider this a breach of the regulation.

Whether the CQC had conducted a raid

87. There was a thread that ran through the case in which Mr Ayokosak stated that the inspection in July was a raid and not an inspection site visit and therefore questioned the legitimacy of the site visit.

88. Having considered the documentary evidence the Tribunal concluded that Mr Ayokosak was given sufficient notice of the inspection. An email was sent to him in July and he agreed to the visit occurring.

89. Mr Ayokosak in our view demonstrated a fundamental lack of understanding of the role of the CQC. He considered that in his view all the documents requested by CQC were provided by Holistic Health Limited, and issues should be dealt with by a re-inspection to confirm any further changes. His position was that, had this had been done, the CQC will have probably concluded that his premises are suitable for the regulated activity. Ms Monteith explained that the reinspection did occur in July. He also considered that CQC inspectors such as Miss Ward did not attend the hearing and therefore deliberately avoided the possibility of scrutiny. We rejected the premise that there was deliberate avoidance of scrutiny and considered that the inspection was legitimate and professionally conducted.

90. We did not consider that there was any prejudgement prior to the July inspection or that it was "gimmick" or "raid" as argued by Mr Ayokosak. Nor did we consider that there was any merit to the Appellants assertion that the Respondent had not addressed the concerns raised by the Appellant in the NOP and NOD nor that they had not considered documents like the Appellant's Representation or at least did not act on them by addressing them. We considered that the Respondent had acted within it's statutory remit and that they had provided evidence to support their conclusions. Notwithstanding that. The Tribunal reminded itself that it was looking at the matter afresh in any event.

Conclusion

91. The Tribunal were concerned that the evidential documentation before us from the Appellant was significantly lacking in addressing the concerns raised by the CQC in respect of Regulation 12 and 15.

92. The Tribunal were also concerned in respect of Mr Ayokosak's ability to understand the role of the regulator, namely that it was not there to act in a consultancy or advisory capacity that took it outside its role as an inspectorate. We did not consider that there was sufficient improvement from 20 December 2022 to 19 July 2023 and we were concerned at the Appellant's inability to identify any of the issues.

93. The Tribunal accepted that there was a lack of evidence regarding governance, compliance and robust systems. We concluded that we could not be assured that the systems in place were adequate and no assurance can be given that the Appellant is capable of providing a service that is complaint with Regulation 12 and 15.

94. Having balanced the impact of the decision upon the appellant and service users against the impact upon the public interest in the promotion of the health, safety and welfare of people who use health and social care services, including the respondent's ability to fulfil its registration function we find that the decision was (and remains) fair, reasonable and proportionate.

Decision

The decision refuse to vary registration is confirmed and the appeal is dismissed.

Judge S Iman

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

Date Issued: 13 March 2025