First-tier Tribunal Care Standards

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

NCN: [2025] UKFTT 00338 (HESC)
[2023] 5166.EA

Hybrid Hearing at Royal Courts of Justice
On 21 October to 1st November 2024

Before
Tribunal Judge Iman
Specialist Member Miss R Smith
Specialist Member Mr J Hutchinson

Between:

Mitchell's Care Homes Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Application

1. The Appellant, a provider of care and support to people living in supported living settings, appeals against the Respondent's Notice of Decision ("NoD") dated 2 October 2023, to cancel the Appellant's Registration as a Service Provider in respect of the regulated activity of Personal Care (the "Regulated Activity") at or from Head Office, Unit 3 Shawlands Court, Newchapel Road, Lingfield RH7 6BL now Bridgeham Grange Annex, Broadbridge Lane, Smallfield, Horley, RH6 9RD.

2. It was brought to the Tribunal's attention that there were two linked appeals; the first against the Appellant relating to the Regulated Activity Accommodation for persons who require nursing or personal care under Tribunal reference [2023] 5139.EA and another against the Registered Manager, Lindsey Goodson, in respect of the Regulated Activity Personal Care [2023] 5170.EA. The appeal under Tribunal reference [2023] 5170.EA commenced in July 2024 and had gone part heard until January 2025. The appeal under [2023] 5139.EA commenced in October 2024 but was withdrawn part way through proceedings.

3. Mr Ageros KC raised with the Tribunal that one of the Tribunal Members, Miss Smith had been part of the Tribunal for the withdrawn case. Neither party objected to Miss

Smith hearing this case and the Tribunal also satisfied itself that there was no issue with Miss Smith taking part in this hearing. Miss Smith is an experienced Tribunal Member and was confident that she was able to place the other hearing out of her mind. Further, the previous hearing was not discussed with the Tribunal at any stage.

4. In respect of the part-heard appeal relating to Lindsey Goodson, the Tribunal did not have any knowledge about that case and did not make any inferences or conclusions in respect of this. The only fact known to the Tribunal was that there were linked appeals and what the panel were told about the appeals, namely that Mitchell's Care Homes Limited (MCHL) is no longer seeking to maintain the Registration for its residential care settings. The Tribunal heard that this would free up MCHL personnel to concentrate fully on its supported living settings which represents the main component of its regulated activity.

Background

5. Between 14 May to 6 June 2023, the Respondent carried out an inspection at the Appellant's Head Office. As part of the inspection, the Respondent visited 11 settings where the Regulated Activity is carried on by the Appellant.

6. At this inspection the Respondent identified the following breaches which demonstrated that the Appellant was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "2014 Regulations"):

> Breach of Regulation 9 (Person Centred Care), Regulation 10 (Dignity and Respect), Regulation 12 (Safe Care and Treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment), Regulation 18 (Staffing), Regulation 19 (Fit and Proper Person Employed) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

7. On 26 June 2023, the Respondent issued a Notice of Proposal to cancel the Appellant's Registration as a service provider in respect of the Regulated Activity at or from Head Office, Unit 3 Shawlands Court, Newchapel Road, Lingfield RH7 6BL. On 21 July 2023, the Appellant submitted written representations. Following the review of the written representations, the Respondent was not satisfied that the Appellant had addressed the breaches as set out in the Notice of Proposal and issued the Notice of Decision.

8. The Appellant, in its grounds of appeal and further in its witness evidence accepts some of the allegations made by the Respondent and submits it has made changes and improvements in appropriate areas. However, it maintains that the Respondent's decision to cancel its registration was disproportionate and wrong.

9. The Respondent conducted a further assessment (inspection) of the Appellant under the single assessment framework in April 2024; and at the request of the Appellant expanded that focussed assessment to a full inspection, covering all domains in June 2024. The Respondent has produced further witness statements and evidence of August 2024.

10. The Respondent maintains that its decision to cancel the Appellant's registration as a service provider in respect of the Regulated Activity is reasonable, proportionate, and justified. The Respondent opposes the appeal in its entirety.

The Hearing

11. The hearing took place over 10 days on from 21st October to 1st November 2024. The parties and their witnesses attended in person at the Royal Courts of Justice. The Tribunal met remotely for deliberations on the following dates: 10th & 11th Dec 2024 and 22nd, 23rd & 31st January 2025 following receipt of written submissions from both parties.

Attendance

12. Natasha Mitchell attended as the Nominated Individual and Lindsey Goodson attended as Registered Manager. Other witnesses who gave oral evidence were Charlotte Jones (Chief Operating Officer of BKR Care Consultancy Limited) and Parent A (parent of a service user); they attended for part of the hearing. On some days, Bibi Mitchell, Director of the MCHL attended remotely. Her witness statement was read into the record and she did not provide any oral evidence. They were represented by Mr Ageros KC.

13. The Respondent was represented by Mr Connor and the following witnesses attended: Clare Creech (CQC Inspector), Emma Steele (CQC Inspector), Susan Kavanagh (CQC Inspector), Amy Jupp (CQC Inspector) and Simon Abbott (senior manager of Learning Disabilities and Autism Team, Surrey County Council).

14. The parties took a pragmatic view and read the following witness statements into the record: Gail Winnery (CQC Inspector), Charlotte Trenchard (CQC Inspector), Stacy Newark (CQC Inspector), Niamh Coyne (CQC Inspector), Charlotte Condon (CQC Inspector), Kelly White (CQC Operations Manager). It was made clear to the Tribunal that this evidence was not accepted but that the cross examination would be focused with the main inspection witnesses to ensure the hearing completed in time. The Tribunal have therefore read the witnesses statements.

The parties' position

15. The Appellant submits that the Respondent's decision to cancel Mitchell's Care Home Limited (MCHL) registration in regards to the supported living services was disproportionate and wrong, and that the imposition of lesser conditions would have been both proportionate and sufficient.

16. They consider that the Respondent has wrongly identified systemic failures to exist, misconstruing evidence of individual failings for evidence of systemic failure. Moreover, it has failed to take proper account of the Appellant's ability to improve, or of actual improvements made. They maintain that it was a theme throughout the hearing that the inspectors had been hypercritical throughout the hearing.

17. The Respondent's position is that the Appellant has not demonstrated sufficiently

that there is now compliance with the regulations pertaining to (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations")) at Head Office ("the Service"); and the Respondent has acted reasonably and proportionately in its decision to cancel the service.

The Law

18. The powers of the Tribunal on appeal are set out in section 32 Health and Social Care Act 2008 ("HSCA 2008"). The issue is determined afresh and is not a review of the Respondent's decision. The Tribunal may take into account circumstances and evidence since the Notice of Decision was issued. It may confirm that decision to cancel or direct that it shall not have effect. In the latter case, the Tribunal may impose conditions on the Appellant's registration or remove any of the current conditions.

19. In the present circumstances, the Appellant is said to be in breach of 17(1)(c) of the HSCA 2008, namely, that "the regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements".

20. As such, the Respondent (or the Tribunal which decides the matter afresh in the circumstances pertaining at the time of its decision) must exercise such a power fairly and proportionately. In essence, the Tribunal has to determine and make findings of fact about breaches of relevant requirements and if so, whether cancellation of registration is a proportionate and necessary step.

21. The burden of satisfying the First Tier Tribunal that the threshold is met lies with the Respondent on the balance of probabilities. The Tribunal may either confirm the Respondent's decision to cancel or direct that it shall not have effect. If the Tribunal decides that cancellation should not have effect, it may consider imposing conditions on the Appellant's registration.

Pre-liminary issues

22. At the outset of the hearing, Mr Ageros (KC) on behalf of his Counsel requested an explanation as to why the Respondent had not selected sample allegations or ranked them in terms of seriousness. Mr Connor on behalf of the Respondent stated that the Respondent's case was opened on the basis of the allegations being cumulative. He explained that, and further clarified that in his written submissions, that the Respondent has not sought to 'rank' the issues and allegations in this matter as per the Order of Judge Khan. Such an exercise would have been arbitrary and artificial as this is not the framework within which the CQC operates as indeed any breach of the Regulations is a serious matter. The matters set out in the Scott Schedule are those for which the Respondent viewed as being "best evidenced" of the breaches.

23. While the matter was opened on the footing that the cumulative effect of the breaches created a situation of such seriousness that cancellation was necessary and proportionate, in later submissions from Counsel for the Respondent it was suggested that some breaches were serious enough on their own to justify cancellation. This was clarified in the written submissions as the most serious breaches were outlined and evidenced within the Notice of Proposal ("NoP") and the Notice of Decision ("NoD") respectively. The Tribunal was advised; *Each of the breaches outlined within the NoP*

and NoD and Scott Schedule amounts to a standalone breach of the Regulations. In some cases, breaches were assessed individually as 'high' in terms of seriousness of breach (C5347 // 5348 – Enforcement Decision Tree). In other cases, it was the cumulative effect of breaches which together were then assessed as 'high' in terms of seriousness of breach (C5347 // 5348 – Enforcement Decision Tree).

24. The Appellant submits the Tribunal would be entitled to infer that the refusal to prioritise breaches according to seriousness involves an acceptance by the Respondent that none - or no group - is serious enough on its own to justify deregistration. That was not how we understood their position. The Appellant was critical of the CQC in stating that how many breaches must there be to justify cancellation of registration? *If one posits a given number of breaches which are not ranked according to seriousness, does one less than that number not justify deregistration but one more does?*

25. We considered that the CQC exercised their judgment in respect of the breaches and where we have disagreed with that, we have expressly stated so and have considered the principle of proportionality when considering the allegations and breaches.

26. It was also brought to the Tribunal's attention that the final report from the April / June 2024 Assessment had been drafted and was undergoing final checks but had not yet been published. The Tribunal was informed that it did not have this report.

Decision tree

27. The Appellant submitted that the Tribunal has not been provided with adequate evidence to show that CQC took into account all of the relevant material, including material provided by the Appellant after the 2023 inspection, when reaching decisions. An application was made to the Tribunal in respect of the decision tree meeting minutes to be provided. We did not consider that this was required for us to understand the evidence before us. The Tribunal had the benefit of hearing from the CQC inspectors, and their evidence was tested in cross examination. We considered that we had extensive evidence before us that demonstrated the decision making.

28. Mr Ageros KC also requested Inspector Creech's inspection notes to be provided (Day 4). The CQC objected on the grounds that they included confidential remarks parents had made to the inspectors. The Tribunal again did not consider that it was in the public interest for the notes to be disclosed as we had extensive evidence before us, and the inspector was available for cross examination and had dealt with the matters in her witness statements.

Additional /Late evidence

29. At start of hearing, the Tribunal was presented with a Supplementary Bundle (Section F: F1 to F202) which included the late evidence of:

i) witness statements of
    i. Kathy Thompson (unsigned)

ii. Rob Larson (signed)
iii. Vanessa Coatman (unsigned)
iv. Kim Pollard (signed)

ii) third witness statement of Natasha Mitchell and exhibits NM3/1 to NM3/5.

iii) third witness statement of Charlotte Jones and exhibits CJS3 /1 and CJS3/2

30. During the hearing, further documents were admitted as late evidence and added to Section F:

i) fourth witness statement of Lindsey Goodson and exhibits LG4/01 to LG4/34.
ii) second witness statement of Simon Abbott (signed)
iii) third witness statement of Simon Abbott (unsigned)
iv) Factual Accuracy Report
v) Care notes of SUII
vi) Examples of Access
vii) Examples of Lessons Learnt
viii) Citation Training matrix
ix) Incident tracker and a larger print version
x) Safeguarding Overview of incidents dated 8th & 10th May 2024
xi) Staff & Service User key
xii) Summary Scott Schedule
xiii) Updated Summary Scott Schedule

31. In addition, a complete set (143 pages) of SUO's Care Plan was submitted as the version exhibited in the bundle at ES/01 (C4540) was incomplete. Following the hearing, the Tribunal received the parties' written submissions.

32. In the written submissions, the Tribunal was warned against double counting allegations and reminded that the Appellant agreed to forego cross-examination of at least 4 CQC witnesses to ensure the evidence phase concluded within 2 weeks and that the Tribunal should be careful not to conclude that an unaddressed matter is accepted by the Appellant. We have proceeded on this basis but in respect of double counting, we consider that an act can breach more than one regulation and in the small instances, where this has occurred we have made reference to it in the decision below.

Issues

33. The key question for the Tribunal is whether the Respondent is able to demonstrate, on the balance of probabilities, that the decision to cancel the registration of the Appellant remains a proportionate and reasonable one.

Evidence

34. The Tribunal read the bundle in advance which included, for each witness called, their witness statements and the Tribunal agreed this should stand as their Evidence-

in-Chief. The Tribunal heard oral evidence from the following witnesses:

35. For the Respondent: Clare Creech (CQC Inspector), Emma Steele (CQC Inspector), Susan Kavanagh (CQC Inspector), Amy Jupp (CQC Inspector) and Simon Abbott (senior manager of Learning Disabilities and Autism Team, Surrey County Council)

36. For the Appellant: Natasha Mitchell (Nominated Individual), Lindsey Goodson (Registered Manager), Charlotte Jones (Chief Operating Officer of BKR Care Consultancy Limited) and Vida Allen (parent of a service user).

37. This was a case where the documentation was extensive and therefore, we are unable to reference all the evidence in this decision. However, we have considered all the documentation and oral evidence that was before us, and we have referenced the key evidence that we have relied upon where possible in determining our conclusions. In order to assist the parties, the Tribunal have collated our decision in a table which is attached to this decision for ease of reference. We have also followed the order of the allegations that was presented to us in the updated Summary Scott Schedule in respect of our conclusions.

Tribunal Conclusions with reasons

38. The Tribunal reminded itself that we are looking at matters afresh. We do that by taking into account all of the evidence in the hearing bundle and the oral evidence from all the witnesses. We have applied our minds to the relevant law. We have considered at all times the principle of proportionality, which we must consider.

39. We have carefully considered the written and oral evidence and submissions dealing with the issues which remained in dispute as set out in the Scott Schedule. The Tribunal reminded itself that the evidential burden rests with the Respondent. We are grateful to all of the witnesses who attended to give oral evidence at the appeal hearing, which assisted us significantly in reaching our decision.

40. We found the inspectors that attended on behalf of the Respondent to be credible witnesses and found that their evidence was supported throughout by the documentation. We were impressed with their oral evidence which was relevant to our role in assessing whether the decision to cancel registration remained a proportionate one as of today. We had the benefit of their detailed observations and findings from the inspection, as well as their comments on points made by the Appellant in their written representations.

41. We also considered that the Appellant's witnesses were also credible and also sought to assist the Tribunal and we understand the importance of the appeal for them. It was clear that they were committed to the MCHL but we found that they were at times fixated in their view in respect of their position that the CQC was being hypercritical and were unable to understand why they had failed to demonstrate compliance with some of the regulations. We attached limited weight to the evidence of Miss Jones due to her limited direct contact with the supported living settings; The Tribunal noted that her initial visit was to the Head Office & 3 care homes (not supported living) in July 2023. Further that in respect of the 4 action plans generated: 1 was for Head office which focussed on organisational matters, the other 3 were for

care homes not supported living. A further follow up site visit occurred in February 2024 which she was unable to attend.

42. At the site visit July 2024 - Miss Jones in her evidence confirmed that 8 settings were seen and on 2nd October 2024 –namely the last visit – she attended the settings but as the visit was unannounced, there were no service users in the settings for her to observe.

43. We concluded that the first witness statement from Miss Jones was based on the limited knowledge of settings; and therefore, attached it little weight. In respect of her second witness statement – we considered that it focused on the response to the Draft Report that had been received and we still considered that Miss Jones had limited knowledge as she did not attend settings in February and that her third witness statement focused on 3 care homes not supported living as there were no service users in the settings on that visit and therefore again we gave it little weight.

44. We also considered that the action plan and the explanation about RAG ratings was unclear and not helpful. Individual settings were not broken down, so it was unclear to see which setting had completed an action and which were still outstanding.

45. The action plans also had no deadline dates; they in our view lacked robustness and this impacted on the reliability of Miss Jones' conclusions. We considered that much of her input appeared to be remote and looking at documentation as opposed to attendance at the settings.

46. We also considered the witness statements that were read into the record and bore in mind that the evidence had not been tested in cross examination. Where we consider that we have placed material reliance on those statements, we have mentioned it below.

47. Throughout the tribunal hearing there had been disagreement between the parties as to the purpose and extent of the Scott Schedule. The Respondent explained that the Scott Schedule was not intended to be an exhaustive document setting out all issues and allegations in this case. To have done so would inevitably result in a document of unworkable and impractical length. Not all issues and allegations, they said, were contained within the Scott Schedule. To that extent, they encouraged the Tribunal to take the view that the matters contained within the Scott Schedule are a useful selection from which to assess the wider picture at the Service. However, for completeness, the Tribunal would like to make clear that we did not consider any allegations outside the Scott Schedule. Some of the issues and allegations were removed from the Scott Schedule during the course of the Tribunal hearing (for example, items 36, 38L-M, 59A-C, 62A-C during Inspector Creech's evidence) as the Respondent considered that further evidence had been supplied by the Appellant which sufficiently mitigated these issues but explained that they remained an important part of the background context upon which the Tribunal can draw.

48. The Respondent explained that they considered the assessment of all the breaches as presented in the Enforcement Decision Tree and came to their professional judgment that the breaches justified cancellation of the service.

Tribunal conclusion

49. The Tribunal must make a determination on whether the Appellant is compliant with the Regulations as at the time of the tribunal. Therefore, whilst inspection history and previously identified breaches are an important consideration – the Respondent contends that the persistent nature of these breaches is conclusive of the Appellant's inability to sustain any improvement.

50. We bore in mind that between the 2019 inspection and the 2023 inspection, the Service more than doubled in size. However, it was apparent during evidence that little planning had been given at any stage to reducing the size of the Service in order to help manage it. Nor had any meaningful consideration been given to an increase in the management structure until after the 2023 inspection. Miss Mitchell explained during her evidence that she has determined that it will require 4 Registered Managers moving forward to properly manage the Service. It was unclear to the Tribunal how this conclusion had been arrived at and that the Appellant currently only has 2 Registered Managers in post.

51. The Tribunal heard that one newly appointed Registered Manager (a potential third RM) had returned overseas to care for a terminally ill relative, and there was no clear timeframe for his start with the Appellant. In addition, there is no longer a HR manager in post. They left MCHL 2 weeks prior to the hearing commencing. The tribunal was advised that MCHL were currently recruiting; however, it was not apparent when a new HR manager will be employed.

52. We also bore in mind that the Appellant continues to receive support from third party organisations including Surrey County Council, BKR Consulting and Fulcrum Consulting. Minimal evidence was provided in relation to the extent of the assistance Fulcrum Consulting offer to Ms Goodson.

53. It was clear to the Tribunal that Miss Mitchell and Miss Goodson were passionate about MCHL and sought to engage with external agencies to seek improvement. This was acknowledged by Simon Abbot of Surrey County Council.

54. However, he also described an intensive support package which has been provided to the Appellant since April 2023, which was "ramped up" in December 2023 and is still in place. Mr Abbott stated that the support would need to continue in his view as the Council have a duty to ensure care is being provided safely. Mr Abbott did explain that such a level of support was not normally given to providers at such an intensity for such a period of time.

55. Charlotte Jones of BKR Consulting was dismissive of the level of support stating that it was nothing out of the ordinary. However, we preferred the evidence of Mr Abbott that this was exceptional, especially given its length of time.

56. We accepted that the sample of settings assessed was sufficient during both inspections. The Appellant states that the sample was small in 2024. However, we noted that the Appellant was able to select most of the settings they wished to be inspected and there were extensive issues identified. We did not accept that the small number of settings visited does not represent a sufficient sample on which a proper

assessment can be made.

57. The Tribunal also bore in mind and took into account the report when MCHL was inspected in 2019 by the CQC (CQC report, published 16/1/20); when Head Office and one setting was inspected. CQC found MCHL to be Good in 4 domains (safe, effective, caring and well-led) and Outstanding in the responsive domain. The Tribunal notes that Lindsey Goodson was the Registered Manager (RM) for this 2019 inspection, and that she was also in place for the improvement process from 2017-18.

58. Lindsey Goodson has been in post at MCHL as RM since 2008 and the Appellant stated that she brought long experience and dedication to the RM role. Unfortunately, the Tribunal did not find Miss Goodson to be a persuasive witness. We understood that she brought experience in respect to working with the service users on a day-to-day basis, but we were not persuaded at her knowledge around safeguarding and strategic thinking.

59. Further, again with Miss Mitchell, though we found her committed to MCHL we did not consider that she was experienced in respect of risk assessments, safeguarding and strategic thinking that would be required to ensure the safe running of the service.

60. It was submitted by the Appellant that good systems and processes were still in place in 2023 since the 2019 inspection, although they may have been overstretched; other factors had also come into play during the period 2019-2023. However, the Tribunal did not accept that this was solely due to outside influences. At the 2019 inspection, there were 25 SUs in 9 settings; this then more than doubled to 57 SUs in 21 settings as at the 2023 inspection. There was insufficient planning in place. Admittedly, this coincided with the Covid pandemic which affected all care settings to a great degree, and we were referred to the cost-of-living crisis; but we consider the amount of failings identified was due to a strategic lack of oversight.

61. Finally, it is important that the Tribunal mentions the service users and the parents that gave their testimonials to the Tribunal. We heard from a parent A who spoke at the Tribunal about how she and the staff at her son's setting work as a team to ensure SUHH experiences as full a life as possible; how she feels entirely safe with their management of his medication; how MCHL treats her son with dignity, and how he has now returned to education; how he enjoys activities such as swimming, cycling and trampolining in the local community and that if had to move again – "he would be destroyed". However, the Tribunal must consider when making its conclusion the overall public interest in safety and efficacy in the running of the service.

62. Further in respect of whistleblowing as the cause of the 2023 Inspection, the Tribunal would like to make it clear that it has not taken any whistleblowing matters into account when coming to its own conclusions.

63. The Tribunal have broken down the allegations below due to the volume of the nature of the allegations brought by the CQC. Having completed the exercise of looking at each allegation individually, we considered that we agreed with the conclusion of the Respondent. In the number of concerns that we considered, there remained ongoing risks and we concluded that there was insufficient oversight, systems, and strategic capability to ensure the safe and effective running of the

service. We were particularly concerned in respect of risk assessments, safeguarding, safe recruitment of staff and the ability to recognise issues that need addressing through a robust auditing process.

Regulation 9 Person Centred Care
Mental Capacity
April 2024

Allegation 34 - Found proved
Various mental capacity assessments within SUO's care plan had all assessed SUO as lacking capacity.

64. During the inspection it was found that that mental capacity assessments were not completed fully. An example given was that SUO's consent record was signed on behalf of SUO by one of the registered managers to consent to SUO having photographs taken and to share information with healthcare providers. There were no capacity assessments linked to these two decisions and no further information regarding how consent was obtained. It is accepted by the Appellant that the two capacity assessments were missing for SUO. These have now been completed in relation to taking photos and sharing information on 26 June 2024 following the inspection.

Allegation 34i and 34ii - Found proved
The mental capacity assessment and best interest decision and monitoring for SUX.

65. The mental capacity assessment and best interest decision for SUX did not identify any other less restrictive options such as sensor mat to allow SUX privacy in their bedroom or undertake a risk assessment. This was accepted but the Appellant explained that the parents had requested the video monitoring as that had been in place at the previous setting and that due to the presentation of silent seizures that it would not assist. At the hearing the Tribunal was informed that there were sensor mats now in place. Therefore, following the inspection action was taken.

Allegation 34 iii (a-d) - Found proved
The Appellant failed to complete mental capacity assessment for SUW.

66. The Appellant accepted that the allegations were correct at the time of the inspection in respect of the Mental Capacity assessments for SUW. They maintained that the best interest decision did explore other options but accepted that it did not relate to clothing. Therefore, action taken to correct this was after the inspection in June 2024.

67. The Tribunal considered that corrective action was only taken when the issues had been identified and pointed out by the CQC. The Tribunal were concerned that despite the Appellant maintaining that systems and processes were in place and changes had been made to them since the 2023 inspection, they failed to identify matters that were fundamental to mental capacity and best interests. The Tribunal was not satisfied that the risk was mitigated but that it remained ongoing as no adequate explanation was provided as to why these matters had not been identified.

Life Histories and background
<u>May/ June 2023</u>

Allegation 3 (a-f) - Found proved
The Appellant failed to ensure service users' care plans contained information around their life histories.

68. The Appellant did not accept that they failed to ensure that there was any information regarding service user life histories in care plans and maintained that the care plan did include life history information, but this had not (at the time of inspection) been transitioned to the electronic system.

69. The Appellant states that they immediately made a conscious effort to review and update *all* life histories following the April 2023 inspection, not just the ones the Respondent identified alleged issues with. The Tribunal were advised that these had been updated with the involvement of service users and families, and staff members are aware of where to find this information should they need to refresh themselves on the content.

<u>April 2024</u>
Allegation 35 (a-c) - Found proved
Some staff continued to have a lack of understanding or knowledge of SU's life histories and backgrounds.

70. In the most recent inspection, it was alleged that a number of staff members continued to demonstrate that there was a lack of knowledge about the service users. Having carefully considered the evidence of Inspector Clare Creech, we did not consider that there was any reason to doubt what she explained was said to her by staff members and therefore found the allegation 35 (a-c) as proved. Further we noted that it was mentioned by the Appellant in the response to the allegations that some service users were better known to certain staff members than others; and that as some staff members were newer than others, they may not be as familiar with the service users. This accounted for some staff members commenting that they did not know much about a service user or that their knowledge was limited.

71. It is properly and fairly conceded by the Respondent that improvements were made to the care plans by the time of the 2024 inspection. This was reflected in Ms Creech's supplementary evidence. However, the Tribunal were concerned that whilst the documentation had been amended and updated following the 2023 inspection, the issue persisted in respect of staff members who had not absorbed and understood this information. Ms Creech reports that staff member ("SM") 8, SM40 and SM50 all confirmed that they had a poor knowledge of the life histories of the service users they were supporting.

72. The Tribunal accepts that the staff members had limited knowledge; our concerns relate to the lack of understanding of the fundamental requirements of life histories and that this was an ongoing issue. We did not consider that the life histories were sufficiently clear, and the information was limited and insufficient at times to assist those providing care with an understanding of the service users. The explanation provided as to reasons for the short comings was insufficient to satisfy us that there

was no ongoing risk.

73. The Tribunal were told that care plans are reviewed and audited monthly by the Appellant and that the BKR Consultancy sampled some of the life histories to check the detail.

74. The Appellant sought to demonstrate in the Tribunal that the care plans did contain sufficient information and that in any event, this is a highly subjective matter, and this was demonstrative of the CQC being overly critical. Their position was that plans did contain background information, although not necessarily in the exact format the CQC expected.

75. The Tribunal took into account the need for proportionality in respect of the length of care plans, but we considered that these allegations were made out. During cross-examination, it was suggested to both Ms Creech and Ms Kavanagh that brief details of when a service user moved into the service constituted a life history. This proposition was rejected by both witnesses, and it is also rejected by the Tribunal.

76. Particularly, we considered that it was concerning that the information was not provided in one succinct place. We accept that the information was extremely limited and not readily accessible, therefore, we consider that the allegations are made out. We did not consider that the inspector erred in not specifically requesting that the SM should point all places where they could find that information, for this does not detract from the extremely limited information contained within the documentation. The collective effect of this widespread failure, was underlined by staff members not being aware of any information in respect of SU's life histories, amounted to a breach of Regulation 9.

77. We further, noted that this had been an issue identified in both inspections. We did not consider that there was sufficient improvement and further that there was a failure in the Appellant's own understanding, systems, and oversight in identifying that the information was inadequate and therefore could not be satisfied that the risk had been mitigated.

Care planning (including behavioural support plans)
May/June 2023

Allegation 5d - Not found proved
SUD - Care Plan stated that they preferred a bath to a shower. SUD's daily notes showed he had a shower twice a day. There was no record of him having a bath in care notes for April 2023.

78. There were clear references in the care plan to SUD having baths. We accepted that there may be issues with the reliability of the use of the shower or bath icon, however we accepted the Appellant's explanation that a high ratio of their staff have English as their second language, which impacts on the nuance of the correct icon being selected.

April 2024
Allegation 37 - Not Found proved

The Appellant failed to ensure that SU's always received compassionate and therapeutic care and support.

79. We did not consider that allegations 37 a- e were made out, in that there was insufficient evidence before us demonstrate that SUs did not always receive compassionate and therapeutic care and support. We considered the positive behavioural support (PBS) plan and noted that the PBS plan had a structure and identified secondary interventions and cross interventions. We considered that the updated PBS plan also included triggers and how to respond. We did not consider that there were fundamental failures in understanding as alleged.

80. Despite 37e being technically correct in that there was no express reference to relational support or trauma informed practice, we considered that there was sufficient information contained with the PBS plan in respect of emotional regulation that we did not consider this to be a breach of Regulation 9.

Activities

May/June 2023

The Appellant failed to ensure service users were supported to engage in meaningful activities.

Allegation 5a – Not Found Proved

81. The Tribunal accepted that the inspector was advised that it was important to SUS to have Heart radio on but that it was not in their care plan. However, we noted the evidence that the Heart radio was playing at the time of the inspection and that the appellant has now updated the care plan to include this information. Therefore, though the allegation is correct as alleged we did not consider that this was a breach of regulation 9 and in any event has been sufficiently remediated.

Allegation 5b - Not Found Proved

82. We had no reason to doubt that this statement was made to the inspector. However, the Appellant states that SM4 was responsible for allocating new activities, looking at online schedules and events and therefore we did consider that her stating that they "had identified the lack of activities people participate in." would not amount to a breach of regulation 9 either individually or cumulatively.

Allegation 5c, e, f - Not Found Proved

83. The Tribunal accepted that it was stated in the care plan they are 'supported to go out once a day in the morning' and 'Staff need to ensure they stick to my routine of going out in the morning'. However, the Tribunal noted that the Appellant indicated that SUD had refused to go out and unfortunately this had not been documented. The Appellant indicated that there had been a failure to document and would ensure that would occur going forward.

84. It is accepted that SUE did not always attend the day centre and that the reasons for this were not recorded. SUE had a period of being unwell and a family bereavement which impacted on her feelings towards activities and leaving the home.

85. Though the Appellant's stated that in respect of SUR that they couldn't comment as it was not brought to their attention, we have no reason to doubt this was said to the inspector, but we concluded that there insufficient evidence before us to conclude that there was a breach in respect of this allegation nor that it was ongoing.

June 2024
Allegation 38 - Not Found Proved
There still remained a lack of activities for some SUs and not all SUs were able to access the community or had a good quality of life in line with nationally recognised best practice guidance.

Allegation 38 (a-d) - Not Found Proved

86. The Tribunal accepted that the allegation as expressed was made out in that there was no record of any activities offered to SUOO. However, we did not consider that that this was a breach of the regulation in that it meant that there were a lack of activities, nor that SUOO was unable to access activities nor that SUOO was not provided with a good quality of life. We noted what SUOO mother states about SUOO access to activities, which was very positive.

Allegation 38 (e–g) - SUQQ Not Found Proved

87. We did not consider that the allegations were made out as within the care plans it stated that SUQQ liked baths and showers, and the care plan refers to their sensory needs and details some ways in which they like to seek out other sensory experiences (not just toys). The care plan details their personal care routine and states they enjoy a bath as this is a sensory moment for them.

Allegation 38 (h–k) - SUII Found Proved

88. The Tribunal did consider that this was made out. In respect of Motability and the issue with the vehicle, the Appellant accepted that this should have been addressed. The issue had to be pointed out by inspectors. Although now addressed we felt there had been little or a lack of a response at the time; there were other ways the Appellant could have supported SUII with going out rather than just accepting the situation. The Tribunal were concerned that there remained a risk of this being repeated if a similar situation arose due to the lack of solution finding that occurred.

Allegation 38 (n–p) - SUZ Found Proved

89. The care plan clearly detailed the sensory diet and activities that were recommended. The care notes between March & April did not record any of these activities. Further in the evidence submitted by Lindsey Goodson, namely the care notes for June 2024, the Tribunal noted that still none of the recommended sensory activities were recorded.

Communication
May / June 2023
Allegation 4 – **Found Proved Overall**

The Appellant failed to ensure staff considered and adhered to service users' individual communication needs.

4a SUB - Found Not Proved

90. The allegation stated that Makaton was the preferred way of communicating and that this was not observed being used. The Tribunal concluded that the care plan referred to Makaton as one way of communicating but did not state this was the preferred way.

4b SUS - Not Found Proved

91. The Tribunal considered that there was limited evidence to determine if the CQC or the Appellant were correct. There was no evidence to substantiate either claim in our view.

4c SUC - Found Proved

92. The Tribunal noted that this was not in the updated summary Scott Schedule but considered that this may have been an oversight, we considered that the allegation was made out. As the advice from SaLT and from the CTPLD team (dated December 2023) was not being followed; there was clear evidence in the letter of recommendations, and we considered that we had been given an inadequate explanation as to why this had occurred, and we were not reassured that it would not occur again.

4d SUX - Found Proved

93. The Tribunal considered that this allegation was made out. The SaLT advice at C420 (use of Grid3 Comm System) was not being followed by staff; there was a lack of a response by the Appellant when the iPad broke, and again we considered we had an inadequate explanation as to why this had occurred and we were not reassured that it would not occur again.

4e SUD - Found Proved

94. This allegation was again not on the updated summary schedule, but we considered that this was an oversight. We considered that this allegation was made out. The care plan clearly details the need to use Makaton and visual aid boards; the CQC saw no evidence of either in use with SUD and again the Tribunal were not reassured that this oversight had been sufficiently understood as to why it had occurred, to reassure us that a repeat would not occur.

April 2024
Allegation 38i - Not Found Proved
The Appellant failed to ensure staff considered and adhered to service users' individual communication needs.

95. The Tribunal concluded that although it was limited there was *some* information about body language and gestures used by SUO, so it was wrong to say there was

NO information. At page 103 of the 143 pages of the full care plan submitted, there was reference to gesture and sounds used.

Regulation 12 Safe Care
Risk Assessments
May/June 2023
Allegation 15 (a and b) - Found Proved
The Appellant failed to ensure that risk assessments were in place or completed.

96. The Tribunal were satisfied that no risk assessment existed for SUQ in respect of epilepsy or supervision in kitchen where there was a risk of ingesting nonedible items.

97. The Appellant considered the allegation in respect of the kitchen to be hypercritical. They referred the Tribunal to the care plan where it referenced SUQ needing supervision and support with helping themselves with food as they were known to eat raw and uncooked food from freezer, along with trying to taste bleach and other dangerous chemicals.

98. The Appellant also recognised following the inspection that more thorough risk assessments were required and updated and implemented risk assessments for all service users and therefore sought to persuade the Tribunal that any risk was mitigated.

99. The Appellant maintained that the Care Plan contained very detailed information on SUQ's medical history as regards epilepsy, including details of GP notes going back to 2019 and medication details and though accepted there was a lack of documents marked "Risk Assessment", did not accept that the information was unavailable for staff to be able to provide safe care. Miss Goodson in her evidence gave an example of a risk assessment and explained that all SUs who require a risk assessment for epilepsy now have one in place. The Tribunal were concerned that the size of the care plan would mean the information contained within it would be difficult to readily access and/or read by staff. We were further concerned that this was another example of where an issue had been rectified only by virtue of it being pointed out by the CQC following an inspection. We considered that no satisfactory evidence was placed before us to provide a sufficient explanation as to why there were no risk assessments. The Appellant had other risk assessments in place for other service users and gave no explanation as to why they had failed to identify that risk assessments were required for these service users.

100. The Appellant maintained there was no systemic or broad problem with a lack of risk assessments, but that these should be seen as isolated incidents where these had not been completed and, in any event, details were contained in the care plans and there were audits now in place. They adduced risk assessments for SUF and SUP as demonstrating that there was no systemic failure and evidenced that these were risk assessments that had been undertaken prior to the 2023 inspection.

101. Though we accept that there was information in the care plan and there was no evidence of poor care, the risk assessment document is a stand-alone document with an objective distinct from the care plan; namely assisting staff to understand, assess and manage risk safely easily and efficiently. The Tribunal were concerned that there

was a systemic failure in respect of identification of issues in the service and rectification of them. We therefore were not persuaded that the risk had been mitigated and that it remained ongoing.

Allegation 16 (a-b) - Not Found Proved
The Appellant failed to ensure that staff were supporting service users with positive risk taking.

102. In respect of SUS, the Tribunal took into account that there was a risk assessment that was in place which provided some guidance on when taking SUS to the shops and accepted that a staff member explained that they would not take SUS into the shops as it was too risky. However, we noted that a referral was made to the Community Team for People with Learning Disabilities and the Speech and Language Therapist. We accepted the evidence of the Appellant that SUS was enjoying going out more and therefore we considered that the risk had been mitigated for this specific individual.

June 2024
Behaviour risk assessment for SUO
Allegation 39 (a-b) - Not Found Proved

103. The Appellant accepted that the risk assessments required further information and updated them. The Tribunal were not satisfied that there was no information in the risk assessment as alleged. We considered that there was limited information in the care plan in respect of emotional support as opposed to no information and there was sufficient evidence before us to persuade us that staff were, for example using music as a distraction and therefore accordingly the allegation was not proved.

Allegation 41 (a-b) - Found Proved
SUSS's care plan states '[SUSS] will self-harm…

104. The Tribunal accepted that SUSS protection care plan stated 'risk of self-harm is high' and that this was the only information regarding the behaviour. There was only one strategy written in the plan in respect of management and that was to call 999. We accepted that they are no risk assessments, mitigating strategies or information for staff to identify when this self-harming behaviour has occurred nor did it contain information in respect of the insertion of objects.

105. The Appellant stated that the care plan did contain some information on this issue but accepted that further detail would have been appropriate and that a full general risk assessment on SUSS regarding this self-harming behaviour and its causes from her past and roots in past bullying and abuse, was required. The Tribunal were concerned that this was not a matter that had been identified by the Appellant through their own processes and was only rectified after the CQC had pointed out the lack of information. Notwithstanding that a risk assessment was now in place, the Tribunal were not persuaded that the risk was mitigated.

Allegation 42 (a-c) - Found Proved 42 (f) - Not Found Proved
The Appellant failed to identify, assess and mitigate risks in respect of providing safe care and treatment.

106. The Tribunal accepted the evidence of the Respondent in respect of SUZ's care notes and that no assessment was in place in relation to the risks associated with enemas. Further, that on specified dates there was no record of any trained staff observing untrained members of staff administering an enema to SUZ and that untrained staff had administered the enema.

107. The Tribunal considered this to be a major failing that had occurred on a several occasions. The Appellant themselves stated they were unclear whether observations had occurred as they were meant too. They maintained that SM19 had been trained by the District Nurse to give enemas but accepted that 3 staff members had not. The Tribunal were aware that the District Nurse had stopped giving training from 8 May. The Appellant's decision that only the District Nurses will do enemas was considered by the Tribunal to be action that was "too little, too late". This was an example of matters that were addressed only when issues had been pointed out by the CQC.

108. The Tribunal did not consider that 42f was made out in that we considered that there was no reference to epilepsy in the risk assessment but that we accepted that the risk assessment provided a good level of detail. Given that there was now an updated risk assessment in place and there had been reference to SUO's epilepsy made elsewhere at the time we considered that the risk in respect of this allegation had been sufficiently mitigated.

Allegation 43
43 a) - Found Proved 43 (b and c) - Not Found Proved 43 (d-g) - Found Proved 43 (h-i) - Found Proved
The Appellant failed to monitor those at risk of constipation.

109. The Tribunal were persuaded that staff were not always recording whether SUW's family had been asked if SUW had opened their bowels whilst visiting with them. Though SUW was away on overnight visits, this did not mean that the family could not be questioned in respect of how SUW had been over the weekend.

110. The Tribunal accept the Appellant's explanation that Movicol was administered and perhaps the inspector meant Senna, which was not administered. Accordingly, 43 b was found not proved, as Movical was being administered and there was recording of bowel movements; generally, the Tribunal could not be satisfied that this placed SUW at risk of constipation.

111. Further, the Tribunal were satisfied that there was a failure to follow the guidance in the care plan and SUW was given bread inappropriately and therefore increasing the risk of constipation. We also were satisfied that there were no fluid targets for SUW or oversight in respect of the amount of fluid intake for SUW. The appellant states that this was due to mostly one individual [night staff] who had been given reflective practice. However, the care notes indicated that there were issues throughout the day and furthermore, there was no explanation given as to why there was a failure by night staff to follow the care plan guidance. The Tribunal were not satisfied that the risk was mitigated as this was another example of deficiencies being pointed out by the CQC and only then, being rectified.

112. The bowel chart for SUII showed that bowel movements were not being recorded as per the CQC's evidence. However, the Appellant stated this was an error as on 16 March the care notes showed there was a bowel movement but that it was recorded under toileting not bowel movement, namely that the wrong icon used; in any event the Tribunal considered that this was NOT recorded on the bowel movement chart as it should have been, so the allegation was proved.

113. The documentary evidence, namely exhibits SK14 & SK15 for May & June, do show that for 12 days in May nothing was recorded; so the allegation is proved. The Tribunal were concerned and queried why this oversight was not being identified up by audits and we considered the risk remained ongoing.

Allegation 44 (a-f) - Found proved
The Appellant had failed to ensure the risks associated with stomas was being managed in a safe way.

114. The Tribunal accepted that there was insufficient evidence before us regarding SUJJ's stoma being blocked. However, the Appellant accepted wrong foods were given to SUJJ on several occasions. They consider that staff are now ensuring correct foods are being given and staff at the setting have been trained in stoma management.

115. There was no risk assessment in SUJJ's care plan with guidance for staff on the signs to look out for if the stoma was blocked. Though the Appellant maintained that no actual issue arose with the food given, we considered this was showing a lack of understanding and appreciation of the risk management. Food was given inappropriately on 28 occasions and though the staff have been trained in stoma management, we did not consider that this addressed the concern raised in ensuring that care plan guidance is followed.

116. Further, we did not consider that sufficient evidence was presented that satisfied us that there was insight and understanding into why staff on multiple occasions had given incorrect food. Further, at no time was this identified in any of the Appellant's processes, audits or reviews. Nor were we satisfied that any future audits or reviews would identify any issues in following the care plan guidance. Though there was a risk assessment now in place, again we were not satisfied as to any insight or explanation as why it did not exist in the first instance. Again, we considered that this was corrective action that only occurred once the issue had been identified by CQC. The Tribunal considered this a major failing.

Allegation 46 - Found proved
The Appellant failed to ensure that risks associated with SUs care were assessed and guidance placed in care plans.

117. The Appellant accepted that there was no risk assessment in the SUAA's care plan at the time of the inspection in relation to their recent diagnosis of Episodic Ataxia. We did not consider that the information that SUAA was being prescribed and was receiving acetazolamide for Episodic Ataxia was sufficient guidance. The diagnosis was issued in February 2024 and the risk assessment was undertaken in September 2024 some time later, following the inspection. We did not consider that this

demonstrated any proactive steps taken by the Appellant and further demonstrated corrective action took place only when the matter was pointed out by the CQC; and therefore we consider the risk to be ongoing in respect of risks being assessed and guidance being placed in care plans.

Care Planning
May/ June 2023
Allegation 14 (a-d) - Found Proved
The Appellant failed to ensure that there was a sufficient information and guidance for staff in service users' records.

118. The Appellant accepted that some of the documents did not have sufficient information and therefore these have been updated which includes documents in relation to SUF and SUM.

119. The Appellant accepted there was no risk assessment in place for SUN, however there was some information in the care plan. The Tribunal considered the care plan and noted that there was reference to the epilepsy diagnosis but no further information in respect of its management. We considered that the explanation that the SUN had been a service user for in excess of 20 years and had not suffered a seizure during that time which meant the risk was low, was fundamentally misunderstanding the failure to ensure that there was sufficient information and guidance for staff in the circumstances for when a seizure may occur.

120. The Tribunal accepted that SM24 could not produce the protocol to instruct staff when medications such as paracetamol and ibuprofen should be administered and did not know where to look for them. However, given the brief reference to this is the inspector's witness statement and given the staff member was no longer working for MCHL, we considered that we had insufficient information before us to satisfy us that this was a breach of the regulation.

121. Further, it was accepted by the Appellant that the choking risk assessment for SUM had no further information on how small the food should be cut up into and no information on the speech and language therapy team (SaLT) being involved; and that SUF's care plan made reference to difficulties in 'eating hard, chewy or mixed consistencies' but did not provide directions to staff of how to respond if SUF were to choke. These both have now been rectified and updated with SUF having seen the SaLT on 3 occasions. However, these omissions were only corrected once again when pointed out by CQC. Therefore, the Tribunal could not be satisfied that the risk had been mitigated.

April 2024
Allegation 40 (a-c) - Found Proved
Within SUSS's Nutrition and Hydration care plan it stated '[SUSS] diagnosed with early diabetes.

122. The Tribunal were satisfied that there were no risk assessments or information in the care plan where it was recorded; no information of the signs and symptoms of diabetic risks for staff to look out for nor any mitigating strategies that staff could use

to support SUSS; or any further information regarding the type of diabetes SUSS had been diagnosed with. We did not consider that this was a recent diagnosis**;** SUSS's care plan indicates that the plan was updated with this diagnosis on 21st Dec 2023**.**

Accuracy and Detail of Documentation (including accidents and incidents)
May/ June 2023
Allegation 12 (a) - Not Found Proved
The Appellant failed to identify, assess and mitigate risks.

123. The Tribunal accepted the Appellant's explanation in respect of SUL, namely that Hydration charts were not requested by the GP and that SUL had capacity and had a fridge in her bedroom with independent access to as much fluid as required. Accordingly, Allegation 12 a was not found proved.

Allegation 13 - Not Found Proved
The Appellant failed to ensure that care records were accurate to peoples' needs.

124. The Appellant accepted that there were some errors in the care records but that these were limited so did not accept these would amount to a breach. They said that the weekly audits undertaken would identify errors of this nature and any incidents could be investigated and if required, reflective practice with a member of staff would be undertaken. The Tribunal noted that two issues had been identified: references to another individual and duplication in some of the care notes however there was insufficient evidence before the Tribunal to suggest this was widespread to the extent that this was or could constitute a breach of the regulation.

Allegation 17 (c) - Found Proved
The Appellant failed to ensure incidents were recorded in sufficient detail with action taken to reduce reoccurrence.

125. The Tribunal accepted that there was no additional information on measures taken to prevent further occurrences of incidents.

126. The Appellant acknowledged that more could have been done regarding incident and accident trend analysis. This has been a key point in their development, of which its instructed care consultants have assisted with.

127. The Appellant explained that they were analysing incidents and accidents during the inspection and did not accept that there was no evidence of this being done. It was accepted that the reporting required more detail and that is now being done and the Tribunal was referred to the incident tracker. The tracking covers all manner of incidents such as medication, falls or bruises/ marks. The Appellant's position was that they were not aware of what incident the Respondent referred to in respect of SUG so was neither able to accept nor reject this allegation nor suggest what more was (or) could have been done.

128. A new Registered Manager with clinical experience has been employed (in role 16/09/2024) which will assist with auditing of incident reporting. Unfortunately, this RM had yet to take up his position as he had returned home overseas to care for a terminally ill family member.

129. The Appellant explained it has educated its staff members on the reporting policy so everyone was aware of what is an incident and how it should be reported. The Appellant's new auditing tool (Access) also assisted with recognising and investigating incidents and accidents. However, the Tribunal was not persuaded that sufficient steps had been taken to understand and mitigate the risk and considered that the risk was ongoing as there was insufficient explanation or understanding provided as to why this had not been identified during their own audit processes and concerns regarding those processes continued to be raised in the 2024 inspection which did not in our view demonstrate effectiveness of any improvements.

April 2024
Allegation 49 (a-b) - Not Found Proved 49 (c-g) - Found Proved
The Appellant failed to ensure, where incidents were recorded, that there was sufficient detail on how these occurred, and the actions taken, to reduce further incidents.

130. The Inspector appears to have mistaken SUA for SUZ and have written the wrong date and therefore the Tribunal considered that it had insufficient evidence in respect of 49 a) and 49 b).

131. The Tribunal accepted that there was no detail on what preceded an incident when SUG was agitated and screaming, and broke the back door, or who else was present. Further that the Nominated Individual did not identify further comments on any learning from this incident. The Tribunal does acknowledge that there is a record at D3089, evidence that the door was to be checked by maintenance and later recorded it had been fixed.

132. There was a further incident involving SUG on 9th April 2024.The Appellant recorded on 14 April 2024 (D3102) that staff had not "flagged" this as an incident, although the incident itself was reported / noted by staff on 9th April. It is recorded that the staff had not identified any possible triggers. There was no further evidence of any investigation into the possible triggers.

133. A note recording the follow up on 16th April (D3103) suggests that the care plan and risk assessments were reviewed but with no other detail. An accident incident form for this incident was exhibited at D3101 (LG29) dated 12th June 2024 indicating that staff had undertaken reflective practice on when to 'flag' incidents and for staff to continue to identify possible triggers. The Tribunal noted that the accident form was completed by LG over two months after the incident and so was not satisfied that the risk had been mitigated.

Allegation 50 (a-b) - Not Found Proved
There was an incident on 14 October 2023 when SUF had a seizure and sustained a cut to their head, an ambulance was called and the wound glued.

134. The Tribunal was satisfied that there was an investigation into this incident. It was investigated and a section 42 enquiry was completed as part of an internal investigation including referral to the CQC and to the Local Authority.

Allegation 51 - Found Proved
Failure to manage SUF's seizures in a safe way.

135. The Tribunal considered SUF's Epilepsy Protocol and were satisfied that the protocol was not being followed and the GP was not consulted. The Tribunal noted that at 12:17 SUF had a seizure lasting 1 second. This was myoclonic seizure and therefore did not engage the protocol. There were a further 3 seizures at 13:36, 13:41 and 15:26. The GP therefore should have been consulted and the Appellant has not demonstrated an understanding and insight into the failure to follow the protocol. Therefore, we consider that the risk was not mitigated in respect of this.

Allegation 52 (a-b) - Found Proved
SUHH became agitated and threw a cup of tea on an external professional.

136. The Tribunal noted the tea and hot drink risk assessment within the evidence. We considered that there was an inference in the notes that the incident occurred due to it being a stranger chatting to SUHH but this is not clearly set out. The risk assessment had been updated on 30th May 2024, sometime after the incident and after the April 2024 inspection.

Allegation 53 (a-b) Found Proved
*SUA had high levels of anxiety and attempted to attack staff***.**

137. The Tribunal did not see any detail to determine triggers. We considered that the accident/incident form document at D3119 was written virtually a month after the incident and identified that a staff member had attended a PBS session and a referral to CTPLD had been made; however reflective practice was still to be carried out with staff. The Tribunal were concerned that this was a matter that had not been addressed by the Appellant in a timely manner, so we were not satisfied that any ongoing risk had been sufficiently mitigated.

Allegation 54 (a-c) - Found Proved
SUA was watching films in their bedroom then ran downstairs and was aggressive to staff.

138. An investigation was carried out and a section 42 enquiry was completed following this incident. The file was made available during the inspection. This was also sent to Surrey Safeguarding Team.

139. We considered that the reference to the use of "high level interventions" was general, vague, and insufficient. As it was identified in the "lessons learnt" document dated 09 March (at D3122) that this implied that restraint was used, when in fact it wasn't. It was also unclear whether this "lessons learnt" document related to the 23 February incident (as the description of the incident reflects that as recorded on 23 Feb – at D3124) or if it referred to the previous 06 February incident as the actions recorded as 'lessons learnt' repeat those recorded on the 06 February accident/incident form (D3119). The "lessons learnt" document did not clarify what interventions were used despite criticising the description used nor did it record what terminology staff should use.

140. The Tribunal did not see any detail to determine triggers. The “lessons learnt” document records that the reflective practice with staff was completed on 30th June 2024 and a review with CPLTD was scheduled for July 2024. The Tribunal are concerned that this was a matter that had not been addressed by the Appellant in a timely manner, with actions only being completed 4 – 5 months after being identified; this together with the lack of clarity within the document as identified above, we were not satisfied that any ongoing risk had been sufficiently mitigated.

Allegation 55 (a-d) - Found proved 55(e) - Not Found Proved
The Appellant failed to ensure staff were appropriately reporting and recording incidents.

141. Miss Steele in her evidence conceded her error in respect of her analysis of the document and therefore allegation 55 (e) was not found proved.

142. It was accepted that there was no investigation into the incident when SUOO “*knocked staff on the head 5 times’* and ‘*Staff called for help from other staff to calm SUOO down*.’ Further, that it was not reported as an incident until 3-4 months after staff noted the incident, so there is a lack of detail on what preceded the incident, or any actions taken to mitigate further risks. The Appellant maintained that this had now taken place. The Tribunal are concerned that this was a matter that had not been addressed by the Appellant in a timely manner, with the incident only being flagged 3-4 months after being reported by staff. The Tribunal could not be satisfied that the risk was no longer ongoing as this was only rectified once the matter had been identified in the 2024 inspection.

Medicines
May/June 2023
Allegation 18 (a-d) - Found proved 18 (e) - Not proved 18 (h-n) - Found proved

143. The Appellant accepts that there were medication errors at Bridgeham Grange. The Tribunal were satisfied that there should have had been 21 Lymeclycline tablets however, there were 22 and there should have been 38 Sodium Valporate tablets (for epilepsy) however there were 40.

144. The Stock count sheet for Haloperidol stated there were 112 x 1.5mg tablets in stock. CQC inspector found there were 140 1.5mg tablets in stock. These errors were acknowledged and the Appellant stated that Medication management within the service has been overhauled, with new procedures and additional resource from its Compliance Managers and administrative support. The Tribunal however were not persuaded that the Appellant had an adequate understanding of why these errors occurred. The introduction of the medication countdown form was an example of yet another form to be completed but did not provide any understanding into why the stock had been missed initially; and how there would be effective monitoring going forward.

145. Staff were giving a medicine (Osteocare) to SUGG that had no prescribing label, and staff had handwritten this medicine on the MAR. We were satisfied that this qualified as a medicine but accepted it was a supplement in nature.

146. Further, we accepted the inspector's evidence that SM16 had not checked with the family member or confirmed with a medical practitioner whether the medication provided for SUGG was safe to give SUGG; and that SM4 told the inspector the medicine had been obtained from SUGG's family.

147. The Tribunal did not consider that it had sufficient evidence before it to be persuaded SM24 had told the inspector that SUX's family member had provided the medication. The Appellant was unaware of any medication provided by SUX's family and considered that the Respondent had confused Service Users.

148. In respect of SUI, the Appellant accepted that medication was being signed off in advance of its prescribed administration time, being signed at 7.10pm rather than 8pm on the MAR chart and therefore signed for in advance.

149. It was accepted that the MAR Chart for both am and pm doses of Lamotrigine had been signed for the following day 24 May 2023. The staff member stated this was because they followed the wrong lines on the chart, however, as there were no gaps in the MAR Chart this meant at some point staff had signed for two days of this medication on the same day. This error had not been identified, which meant there was a risk staff would believe SUI had already received their medicines and fail to administer them. The concern being that the following day, staff members may have determined that the medication had been administered. The staff at this setting have received supervisions and competency has been re-assessed. The Tribunal were satisfied that this was not a widespread issue and that this was an isolated event/ error.

150. In respect of SUEE, the Tribunal was addressed on this matter in submissions also and accepted that there was no risk assessment in place for what action to take if SUEE refused to take his medication despite SUEE being at "high risk" of relapse, due to previous non-compliance with taking prescribed medication and that they may refuse medication when in crisis. The Appellant stated that a risk assessment was now in place, which gave staff clear guidance on what action to take regarding any medication refusal: for instance, to wait 20 minutes and then encourage SUEE again to take it. However, the Tribunal were not persuaded that there was an explanation provided as to why there was a failure to have a risk assessment in place. Though refusal was rare as the Appellant stated, a risk assessment was required. The Tribunal were not satisfied that the risk had been mitigated.

151. Allegations 18 (l) and (m) were also dealt with at allegation 13 and found not proved. The Appellant had requested that the Tribunal exercise in caution in double counting breaches. The Tribunal considered that a failure could engage and breach more than one regulation and therefore we considered they were relevant for this regulation also.

152. The Tribunal concluded that Medication records could not provide assurance that competent staff were supporting people with the administration of medicines as some staff who had signed Medicines Access Records (MAR charts) were not on the designated persons' list. We considered this was a major failing which was a fundamental and basic requirement of providing medication.

153. Though assurances were given that staff members are aware of the reporting and investigation procedures should something occur in the future, and the Nominated Individual retained oversight of these processes, the Tribunal considered that there were errors on more than one occasion without adequate understanding as to why they had occurred and why they had not been identified through the auditing process. The Tribunal were not persuaded in respect of the medication audit representations and considered that the risk remained ongoing.

April 2024
Allegation 57 - Not Found Proved
SUJ has been administered as and when medication (Lorazepam) at the maximum dose without evidence.

154. The Tribunal did not consider that this allegation was made out. The staff were not acting outside the guidance, namely the medication could be administered up to four times a day, to a maximum dosage of 4mg. There was reference in the care notes that SUJ was regularly agitated on these occasions.

Choking
May/ June 2023
Allegation 12b - Found Proved
*SM22 was unaware that SUEE was at risk of choking and the appropriate response if a service user was choking***.**

155. The Tribunal were satisfied that the risk of choking was clearly articulated in the care plan and therefore there had been no adequate explanation provided to the Tribunal as to why a staff member was not aware of such a serious and significant risk and the guidance around it. Though the Appellant maintained that all staff had now undertaken training around choking, there was insufficient evidence before the Tribunal that they had understood why the staff had failed to follow guidance and be assured that adequate learning had been undertaken in respect of preventative measures so that choking does not occur; therefore, the Tribunal considered that the risk in respect of this remained ongoing.

Allegation 19 a and b – Found Proved
Staff were observed not following service users' individualised care needs and guidance in relation to their eating.

156. The Tribunal accepted the evidence of the CQC that the inspector observed that supervision of SUB did not happen consistently. They observed that the staff member on duty, SM11, was in the kitchen preparing drinks and meals for other service users and was not supervising SUB when they were eating. We took into account that it was evidenced that SUB was monitored by the staff member towards the end of the mealtime, whilst SUB was eating.

157. The Appellant accepted that SUU was not closely monitored during meal times.

158. We considered that the Appellant's explanation that neither SUB or SUU are service users anymore and therefore this is not a live issue which requires the Tribunal's consideration was a misunderstanding of the risk of failure to follow

individualised care needs and guidance. There was insufficient explanation or insight before the Tribunal as to why this had occurred and therefore the Tribunal could not be satisfied that the risk had been mitigated, in respect of other service users that may develop choking risks or join the service.

Allegation 44 (a – f) – Found Proved
The Appellant had failed to ensure the risks associated with stomas was being managed in a safe way.

159. The Tribunal considered the allegation and were satisfied that although it related to stoma care, the failure of staff to follow the guidance around 'foods to be avoided' was similar to the risks associated with choking, in that it could lead to a medical event. The Tribunal considered that the risk remained ongoing due to the repeated failures to follow the guidance.

Allegation 47 (a and b) - Found Proved

160. The Tribunal accepted that the care notes for April 2024 showed that on 10 occasions, SUF was given 1 or more of the foods listed in their care plan that should be avoided, placing them at further risk of choking. In June 2024, records show that on 18 days, staff gave foods to SUF that should be avoided. This was accepted by the Appellant in respect of other beans and pulses. They explained that all staff have been given face-to-face dysphagia training by Caring for Care as of 02/10/24. However again we considered that there was no explanation given why this guidance had not been followed by staff initially and we were not satisfied that the risk had been mitigated.

Moving and Handling
April 2024
Allegation 45 (a-c) - Not Found Proved
Poor moving and handling practices observed with SUJJ.

161. This was accepted by the Appellant, and they considered that it had been rectified by training that had been put in place. The Tribunal noted that the care notes were clear that a handling belt was required.

162. The SM seemed unclear on how to use the belt to physically lift SUJJ. This resulted in the SM moving SUJJ from their wheelchair into the lounge chair without using the belt.

163. The Tribunal noted that in the BKRC action plan, all staff will now have moving and handling training annually, with sessions held in May and Oct this year. Staff received additional training on the use of the handling belt to prevent future incidents.

164. The Tribunal considered that due to the regular training, the risk was no longer ongoing.

Regulation 13 Safeguarding
Malnutrition
Allegation 48 - Not Found Proved

The Appellant failed to ensure SUs that were at risk of malnutrition were being supported in a safe way.

165. The Tribunal was not persuaded that SUQQ was at risk of malnutrition. The care plan notes did show that his parents were concerned about his weight but that he had been appropriately seen by the GP. The GP had no concerns regarding his weight, no supplements had been prescribed and no other nutritional professional referrals had been made, therefore the allegation was not found proved.

Financial and Physical Abuse
May/ June 2023
Allegation 20 (a-c) - Not Found Proved
The Appellant failed to protect SUs from the risk of financial abuse as there were SUs at multiple settings who had their own vehicles but there was no robust oversight or audit that petrol or diesel charged to the SUs finance accounts were used for travel.

166. The Tribunal considered that at the time of the 2023 inspection, a breach had occurred in respect of this.

167. It was accepted by the Appellant that not all service users had mileage forms at the time of the inspection, but some service users did have the forms. Other service users, for example, SUU, did not want to have a form.

168. The Tribunal was advised that the Appellant has now implemented mileage forms for all vehicles, including personal service user vehicles. The Tribunal were advised that these are audited each month by Miss Goodson and the Nominated Individual has full oversight over financial arrangements, such as mileage and transaction records.

169. Though the Tribunal were not persuaded by the audit processes/risk assessments in place to assist administrative staff to ensure that nothing is missed or delayed, we were persuaded of the steps that had taken place to implement the forms and ensure that there was an appointee in place for those that did not have capacity. The Tribunal considered that this was a specific area in which they had now mitigated the risk. Further, there had been no repetition of this in the later inspection which took place in 2024.

Allegation 21 (a-e) - Found Proved
The Appellant failed to protect SUs from the risk of physical abuse; staff were not always recognising or reporting abuse.

170. The Tribunal took into account that the Appellant accepted that the incidents referred to were not reported however, they maintained that this was appropriately raised later by the Nominated Individual and the appropriate action was taken by the Registered Manager.

171.The Tribunal accepted the evidence of the inspector in respect of what she was told by SUU and SM2; that the matter had not been referred to the Local Authority and that there was no record of this in SUU's care notes; and that she had observed reports

of further incidents that had taken place on 01 June 2023, demonstrating more physical and verbal abuse towards SUU

172. We accepted that there was some information in the SUV's care notes in respect of how to best support SUV when they were in a heightened state of anxiety, but we considered that it was extremely limited and insufficient so that it could be correctly categorised as a lack of guidance and therefore we considered that this aspect of the allegation was found proved.

173. When considering the risk assessment that was put in place, we considered that though there was a reference to a referral to the Community Team for People with Learning Disabilities, there was limited guidance in the document beyond that.

174. The Tribunal accepted that risk in respect of these *specific* users had been mitigated as SUV no longer lived at the service and that there had been a meeting with SUV's Social Worker and an investigation on the 31 May 2023.

Allegation 22 (a-f) - Found Proved
The Appellant failed to report incidents of alleged abuse to the Local Authority.

175. The Appellant accepted that there was no investigation into the bruises on SUJ following a trip to the hospital which occurred due to the discovery of bruises to the face and head. Further, it was accepted that the bruises to SUT were also not reported. The Tribunal noted that staff had recorded the bruising for SUT as "unexplained" yet despite this, the explanation to the Tribunal was that SUT regularly self-injures, which often involves pinching his skin which creates a bruise and this was determined to be the cause of the bruises. Though this may have been the case, it has not been clearly recorded that this was the Appellant's understanding. On the 05 May, 07 May and 10 May there was bruising noted on the right-hand side of the chest, the eye and the back in respect of SUT.

176. The Tribunal considered that this was a major failing that had occurred on repeated occasions in respect of 2 service users and that this allegation alone was a breach of the regulation due to its seriousness.

177. The Appellant maintained that it had mitigated the risk as the care notes are now audited, and specific attention is paid to service users' skin integrity and it is monitored for any changes. Despite the Appellant stating that weekly analysis of behaviours of concern and incidents of distress are completed from the PCS into Access and that the consultancy BKRC has added their own ABC Analysis form to be considered as part of the process, the Tribunal were not persuaded that the risk had been mitigated.

April 2024
Allegation 60 (a-c) - Found Proved
The Appellant failed to protect SUs from the risk of physical abuse.

178. The Tribunal accepted that the care notes of SUA did record and make reference to the incident that on the 28 March 2024 SUHH swore at SUA and threw tea on them and that this was not reported until the 02 April 2024. The Tribunal were concerned to note that there had been conflicting decisions in respect of this, namely

that on the 03 April 2024 at 13.39 Miss Mitchell had determined that this was not an incident, yet on 03 April 2024 at 13.42 Miss Goodson flagged it as an incident.

179. The Appellant maintained that there was an investigation and the matter had been reported. However, the Tribunal took into account that the decision to report to the Local Authority (Section 42 form) occurred on the 30 May 2024 following the inspection; and was only sent on 07 June 2024.

180. Therefore at the time of the inspection, there had been no details provided in respect of whether the tea was hot nor had there been an investigation or reporting of the matter. This is concerning to the Tribunal and an example of corrective action being taken only once matters had been pointed out by the CQC and there was no sufficient explanation provided to understand why there had been a failure to report and/or why this had not been identified at an early stage despite it being recorded in the care notes.

181. Further, we concluded having heard evidence that there was a lack of understanding and/or insight into the failings around safeguarding and timeliness of reporting. The Tribunal were not persuaded that the risk had been mitigated by the new audits, trend analysis, Access platform and input of BKRC. These are fundamental expectations in respect of safeguarding.

Allegation 63 (a-c) - Found Proved
SUQQ's daily notes on 22 April 2024 record that they had a scratch and two bruises and that pictures were sent to the GP.

182. The Appellant accepted that this incident was not initially reported but indicated that it was identified prior to the service of the CQC statements by a care note audit, was raised as an incident on 21 May 2024 and reported. The Tribunal considered that it was positive that the matter had been identified but we are concerned that there was a significant passage of time in the matter being identified and there was no adequate explanation by the Appellant as to why it was recorded in the daily notes yet took approx. one month to be recognised and raised as an incident. The Tribunal consider that this was a major oversight.

Allegation 64 - Found Proved
Although staff had received safeguarding training they were not always recognising or reporting incidents that required reporting.

183. The Appellant stated that they had taken strong steps to ensure that any deficiencies in training had been rectified. They referred the Tribunal to the Citation training matrix which covered internal and external training, observation quizzes and competency checks. They explained that currently 86.79% of 183 staff members have completed all Citation training. They submitted that as a document the training matrix enables the relevant management to see at a glance who has not had appropriate training. They also maintained that since 2 November that 100 percent of staff had completed 100 percent of the safeguarding modules.

184. However, the Tribunal were concerned that the explanation given for monitoring the training matrix is that when the expiry date for the training is passed, the matrix

identifies this by turning red. It was not demonstrated to the Tribunal that there was a warning system in advance of the expiry date going red to ensure that lapses in training did not occur and were being proactively managed. Further, we did not consider that Miss Goodson as safeguarding lead nor Miss Mitchell had sufficiently persuaded us that they were able to monitor/ understand the distinction between training being undertaken and the safe application of that training. There had been several failures of reporting safeguarding concerns identified at both the 2023 and 2024 inspections and there had been no sufficient explanation given as to why they were occurring. Further, we considered that the competency checks and observation quizzes were not meaningfully testing understanding. Therefore, we were not satisfied that the risk had mitigated in 2024.

Safeguarding
Allegation 61 (a-c) - Found Proved
Care notes for SULL for 29 Match 2024 record SULL was observed trying to hit SUNN.

185. The Appellant accepted that there was an incident that took place on 30 March 2024 and not 29 March 2024 and failed to investigate and report it. However, they explained that it was now investigated and had been reported to social services. The Tribunal was advised that the matter was recorded in the care notes in some detail namely,

> *"This morning SULL without any reason was agitated, and he tried to hit SUNN after they had a conversation. The staff tried to calm him down and gave him reassurance. The staff showed empathetic attitude towards SUNN and gave emotional support to SULL. Later on they both said sorry to each other and had a hug. duration was for 15 minutes, in the dining room"*

186. However, this does not equate to an investigation nor a referral to safeguarding. The Tribunal were not satisfied that the risk had been mitigated and that it had remained ongoing. This was another example of rectifying issues once they had been pointed out to the Appellant by the CQC.

Neglect
Allegation 58 (a-c) - Found Proved
The Appellant failed to protect SUs from the risk of neglect:

187. The Appellant accepted that SUJJ's stoma bag should have been emptied during the night and considered that this risk was now mitigated as it was now being done. The Tribunal accepted that the bag had leaked on 15 days when SUJJ was being moved and that there was no record of the night staff checking or emptying it. The Tribunal was satisfied that there was sufficient evidence to suggest that the failure to check and/or empty meant that SUJJ may have been lying in faeces for a long period of time and accordingly that aspect of the allegation was found proved.

188. This was another example of an issue being raised with the Appellant and only then did they rectify it. Miss Mitchell and Miss Goodson did not satisfy us that they had an understanding on why appropriate stoma care was to being given. They cited that it appeared that they did not want to disturb SUJJ sleeping however we did not

consider that adequately demonstrated that risks of neglect had been or were now properly understood.

189. Though SUJJ was the only service user with a Stoma bag, and the Appellant stated that they had put in place a risk assessment, the Tribunal were not satisfied why a basic fundamental level of care had not been carried out or identified through the Appellant's own processes; further, we are not persuaded by the robustness of the Appellant's own processes that they would now identify the issue, therefore we did not consider that the risk had been mitigated.

Regulation 17 Governance
Closed culture
May/ June 2023
Allegation 23 (a-c) - Not Found Proved
The Appellant failed to support an open culture within the staff team.

190. The Tribunal considered the statements made to the inspector were made in general and vague terms. We considered that we had insufficient evidence before us to satisfy us that the allegations were made out.

Negative feedback from Family members and responding to feedback
May/ June 2023
Allegation 24 (e-f) Found Proved
*Despite the Appellant being aware of these repeated concerns they had not taken appropriate action to act on the feedback received***.**

191. The Appellant accepted that concerns were raised regarding SM4 and that these concerns are accepted. The Appellant has spoken to SM4 about these concerns and an improvement plan was put in place. This improvement plan has been kept under review and the general attitude and demeanour of SM4 is much better. The Tribunal considered that the risk of repetition in respect of this matter had been appropriately dealt with.

Allegation 28 (a and d) - Found Proved Allegation 28 (b and c) - Found Not Proved
The Appellant failed to respond to the views of people who use the service to improve quality and safety.

192. The Appellant accepted that SUN did not have a rotary line at the time of the inspection, but this was remedied before she left the service. The Tribunal considered that this had been appropriately dealt with.

193. The Tribunal accepted that the possibility of a ramp was investigated but SUCC's Occupational Therapist said this was not appropriate and therefore accordingly we did not consider that the allegation was made out.

194. Though the Tribunal accepts that the inspector was told that "they do not recall" a service user meeting being held, we accept the Appellant's evidence on this, that this was not the case. The Appellant conducted service user meetings, as evidenced by the notes the Respondent reviewed for February, March and April 2023.

195. The Tribunal considered the meeting minutes for service user meetings for February, March, and April 2023. We accept that parts of the documents had been copy and pasted such as the action plan and activity planner. Though there were some brief comments added to some parts of the document, the Tribunal considered that this evidenced a poor practice.

Auditing
May/ June 2023
Allegation 25 (a and b) - Found Proved
The Appellant failed to have sufficient audits in place. Appellant unable to provide evidence of an effective system to assess, monitor and improve the quality and safety of the services provided and to ensure they had met the requirements of Regulation 17
196. The Tribunal accepts that the inspector was only provided with audits for 6 of the 16 settings and no audits were provided for:
(i) care notes
(ii) care plans
(iii) staffing levels
(iv) staff interactions with the service.

197. The Appellant maintained that it had overhauled its auditing process with the assistance of its new Access auditing platform. They explained that BKRC initially provided a suite of audits. This provided a foundation for the Appellant to work from. However, this has now been replaced by Access, which they consider is working effectively.
Access covers the audits the CQC has mentioned and extends much further e.g. financial transactions, mileage forms, risk assessments etc which they consider is a vital tool in the management and governance of the service.

Allegation 27 (a and b) - Found Proved
The Appellant failed to identify concerns around staffing levels.

198. The Appellant accepts that there were issues with staffing levels when the Respondent inspected in 2023. The Tribunal were concerned that these breaches occurred despite checks being undertaken by Senior Management of staffing forms and rotas being completed by Team Leaders.

199. However, the Appellant considered that these had now been addressed as this prompted an overall review of care hours and the Appellant continues to work with the Local Authorities on this. The Registered Manager and Compliance Manager undertook a review of all service user hours to determine the correct number of staff required at each location. This is then used to produce the rotas for each location. We considered that this was a basic requirement for the service and were unclear as to why, when checks were taking place, this had not been dealt with adequately. We were not satisfied that this had been sufficiently dealt with (see also regulation 18).

April 2024
Allegation 65 (i (a-d) - Found Proved

There were discrepancies within the accident and incident matrix for the setting Benares.

200. It was identified that one member of staff had been involved in seven of the thirteen incidents at the setting; however, there was no indication that this had been investigated. The matrix was a factual record of incidents but there was no evidence of any analysis of its contents or trend analysis to assist with the mitigation of risks going forward. The Tribunal accepts that it was not adequately audited and that there was no information under the heading titled 'changes made and lessons learned'. The Tribunal also accepts that the Appellant failed to provide evidence of trend analysis in respect of the accident and incident matrix for setting Vennor 2.

Systems and Processes
May/ June 2023
Allegation 26 - Found proved
The Appellant failed to demonstrate processes to monitor and maintain oversight of service users' access to activities.

201. Though the Tribunal accepts that the Appellant is passionate about providing activities to the service users, this allegation related to systems that monitored and provided oversight. The examples provided to the Tribunal were a photobook which was a series of photographs of activities, and we did not consider that this was demonstrative of adequate systems and processes to monitoring the activities' programme. The activity planner section of the service users' meeting minutes were largely copy and pasted month to month (February, March and April 2023) and does not demonstrate that adequate monitoring and oversight was in place.

202. Further, we were referred to a therapy report which again was not demonstrative of the processes and monitoring in place. Therefore, the Tribunal are not satisfied that this had been sufficiently dealt with. We were not satisfied that the risk.

Regulation 18
Staffing
May/ June 2023
Regulation 29 (a-l) (n) (q) - Found Proved
The Appellant failed to ensure there were sufficient numbers of staff.

203. The Appellant accepted that there were issues with staffing levels when the Respondent inspected in 2023. The Tribunal considered carefully the documentary evidence such as handover notes, rotas and were satisfied that all the allegations were made out as per the inspectors' evidence but will not be recited here.
Both parties accepted at the Tribunal that the problems of recruiting and retaining staff are pervasive in the adult social care sector, particularly after Brexit and then Covid. It was an issue affecting the entire industry which the Tribunal also accepts.

204. The Tribunal were advised that the Registered Manager and Compliance Manager undertook a review of all service user hours to determine the correct number of staff required at each location. This was then used to produce the rotas for each location. They would call each location to check that the correct number of staff members were on site each morning in accordance with the rota. As the Appellant has

a consistent body of staff members, the Tribunal was advised that they would often work in the same location and do similar shifts. If there was any sickness, or insufficient staff members, agency staff would be sourced to ensure the stability of staff numbers and safety of service users. Any overtime must be approved by management. This measure was put in place to prevent any staff member working excessively long hours or without sufficient breaks in a working week.

205. The Appellant also stated that the appointment of a new HR Manager from August 2023 greatly helped with the management of staff rotas.
Further, in 2024 and after the CQC's last visit of April 2024, the staffing system has been entirely overhauled by investment in and installation of a Biometric and Facial recognition system in all homes from August 2024. This ensures that issues such as staff swapping shifts with each other to assist each other and consequently working long hours, cannot happen without management noticing.

206. The Tribunal accepts that staffing levels fell below the minimum levels on several occasions and there were issues with covering staff breaks. Staffing issues as identified above were widespread and the Tribunal also were satisfied that on 43 days between 1 April and 14 May staffing levels were below what was required. For example, the inspector had been informed that 5 staff should be on duty during the night at the Benares setting. On the 43 nights between 1 April 2023 and 14 May 2023, 10 occasions were noted when there were less than five staff. We considered that this was high proportion of absence. This was just one example of the failure: another example being, in a 43 day period at Benares, there were 18 occasions when day staff levels fell below the expected 8 staff. Though there were difficulties in the sector, the Tribunal noted that a review had occurred, and corrective action had been taken once the issues had been pointed out by CQC. The Tribunal were concerned that there was no evidence of contingency planning in place or any planning to mitigate risks or identification of the high frequency of absences.

April 2024
Allegation 67 (a-d) - Found Proved
The Appellant failed to ensure there were sufficient numbers of staff providing care which placed SUs at risk they may not be appropriately and safely supported.

207. The Appellant maintained that the position regarding staffing is complex, due to having over 200 staff. The correct numbers may be on the rota, but events sometimes intervene. They said that at times, staff numbers are adjusted to reflect that when a service user may be absent (for example, when visiting family), so it would be unreasonable to expect a full complement of staff on these occasions, as the setting would then be over staffed.

208. The Tribunal carefully checked the documents and were satisfied that the allegations were made as per the evidence of the inspectors and will not be rehearsed in their entirety here for brevity.

209. The concerns that the Respondent set out in 2023, continued into 2024. The 2024 inspection demonstrated a repetition of patterns of staff not working in accordance with the rotas. For example, in her evidence, Ms Goodson stated that although the inspector stated they were informed by 2 staff members that 5 staff were required to

support the Jays during the day, it was in fact 4 staff so she disputed that staff levels were reduced when handover forms indicated only 4 staff were on duty for 11 days in March 2024 and 15 days in April 2024. However, she did accept (D2765, para 83) that on at least one occasion in March 2024 and again in April 2024, only 3 staff were on duty. She gave no explanation as to why staff members working at the setting told the inspector 5 staff were required.

210. The Tribunal accepts that some steps had been taken in order to rectify this, such as the introduction of the biometric system, however we did not consider that they were sufficient to have mitigated the risk and we concluded that the risk remained ongoing. The Tribunal were not persuaded that the systems in place were robust and considered that though there were issues in the sector regards to staffing, these failures related to oversight and the lack of contingency planning for staff shortages.

Allegation 68 (a-b) - Found proved
The Appellant failed to ensure staff were not working long hours and consecutive days which can lead to physical and mental exhaustion which in turn can impact on staff's ability to perform their job effectively and provide safe care to SUs:

211. The Appellant accepted the criticism by the Respondent but stated that investigations had taken place, and, in some circumstances, the staff had been disciplined.

212. The concerns that the Respondent set out in 2023, continued into 2024. In her evidence Ms Mitchell stated that in respect of staff working without a break, this did not happen anymore. Staff are permitted to work four long days, with a day off, or four nights, with a day off and that rotas and staffing levels are audited by Mr Reetoo, the new Registered Manager. However, the 2024 inspection demonstrated a repetition of patterns of staff not working in accordance with the rotas.

213. Ms Mitchell was taken through a number of Day Shift Planning sheets, which demonstrated that SM43 had worked for 10 night shifts consecutively between 01 April – 11 April 2024. Ms Mitchell said that sometimes staff would work more than four days in a row either in an emergency but was unable to assist with why SM43 had worked 10 consecutive shifts on this occasion or whether any investigation or action had been taken in respect of this.

214. In her witness statement (D2766), Miss Goodson commented on SM48 working more than 4 nights in a row without a break. She said he had apologised and had been issued with an improvement plan.

215. In August 2024, the Appellant introduced a 'Biometric and Facial Recognition System for Staff Attendance and Monitoring' so that it can be monitored when staff start and end their shifts. This software will indicate the hours worked, removing the need for paper timesheets to be completed and accordingly, will enable monitoring of staff hours and breaks in the week and also monitor staff ratios. It will also provide real-time data that can show the number of staff present in each home at any given moment.

216. The Tribunal accepts that some steps had been taken in order to rectify this, such as the introduction of the biometric system, however we did not consider that they were sufficient to mitigate the risks and we concluded that the risk remained ongoing. The Tribunal were not persuaded that the systems in place were robust and considered that though there were issues in the sector with regards to staffing, these failures related to oversight and the lack of contingency planning for staff shortages.

Skilled staff and training
May/ June 2023
Allegation 30 (a-c) - Found Proved
The Appellant failed to ensure suitably qualified and skilled staff were deployed to meet service users' needs.

217. The Appellant accepts that there is the possibility that staff did not feel adequately skilled to deal with certain conditions and that the identification of these needs was not identified in a timely manner. Though the Tribunal noted what was said in respect of the training matrix and competency testing to identify if additional support to training is required, we noted that this was a matter that was raised again in 2024.

Allegation 31 (a-c) - Not Found Proved
The Appellant failed to ensure staff received appropriate support that promoted their professional development and assessed their competencies.

218. The Appellant accepted that the supervision forms were not as thorough and comprehensive as they could have been to facilitate development and promote competency. It is accepted that this may have led to missed opportunities for supporting staff. The Appellant's supervision forms have been refreshed with input from the Quality Assurance 219. Team at Surrey County Council. The feedback on these new forms has been positive. It is noted that the Respondent has not raised any comment on the supervision forms in the ongoing inspection. Therefore, the Tribunal were satisfied that this had been adequately deal with.

April 2024
Allegation 69 (a, c) - Not Found Proved, 69 (b, d, e, f, h) - Found Proved

The Appellant failed to ensure suitably qualified and skilled staff were deployed to meet SUs needs.

220. The Tribunal accepts that SM33 did not give the correct explanation for Angelman's condition. However, the Tribunal accepts the Appellant's position on this and did not consider that this did not equate to an inability to meet SUW's needs. We accepted that staff are not medical professionals and therefore may not be able to fully explain conditions.

221. We accept the SM28 staff member did not know what ADHD was but given the reflective practice they have undertaken that this had been sufficiently addressed.
In respect of SM51, there was some understanding that they would call management and next of kin in respect of SULL; however, the Tribunal were not satisfied that SULL would receive the appropriate care in a timely matter due to SM51 needing to seek

advice from colleagues, management or the next of kin on how to manage a seizure, which would placed them at risk.

222. The Tribunal were satisfied that there was no evidence of training for night staff on how to change a stoma bag; and who regularly worked on their own. The Appellant accepted that there was shortfall in training and that this was the only resident with a stoma. However, the Tribunal were concerned that this risk to SUJJ was only rectified due to the CQC pointing out the concern and this was a fundamental requirement in order to ensure that safe care was provided. As noted above, there were failures in not providing the necessary training to staff (for changing the bag) but also in the lack of identification that training was required by the night staff; therefore, the Tribunal were not satisfied that this had been appropriately dealt with and the risk remained ongoing.

223. In respect of SM45 we noted that they had previous training through an agency and had received further training 01 June 2024. We considered that though this did occur, and they provided only a generalised statement of what it meant to be autistic, this was sufficiently dealt with, and in any event, this would not stand as a standalone breach nor contribute to a breach of the regulation cumulatively.

224. In respect of staff members accompanying SUQQ on an activity and being required to take emergency Buccal medicine to administer if SUQQ required this; neither staff member had been trained in how to administer this medication. Miss Goodson indicated that there was a protocol in place, however when considering this, the Tribunal noted that this related to calling 999. The Tribunal considered this a serious omission and are not persuaded that there was any insight into this concern, as calling 999 is not adequate guidance for staff in the absence of training on how to deliver this emergency medication. Therefore, we were not persuaded that this has been adequately dealt with and the risk remained ongoing; due to the lack of understanding regarding the risk demonstrated.

225. The Tribunal were concerned that not all staff at the Park Road setting were trained in working with people with learning disability and Autism. Ms Goodson explained in her witness statement that with regards to the nine staff there, there were 3 without training at the time of the inspection; 2 were on maternity leave and the remaining staff member has now been training. At the hearing, the Tribunal was advised that Autism training is at 100% compliance.

226. The Tribunal were concerned that five out of the nine staff at the Park Road setting were not trained in using a hoist, which was required to support SUO. No explanation has been given for this nor if adequate training has since been given to the staff.
In addition, the training matrix for Park Road exhibited at C5129 indicated that out of the 14 staff members (excluding the 2 staff who are on maternity leave) who support care at Park Road, only one staff member had completed over 80% of the training (having completed 86% of the training scheduled), with 6 staff members having completed less than 60% of the training.

227. The Tribunal were not persuaded that there was the requisite understanding regarding identifying training needs urgently. The Appellant failed to persuade us they

were coherent and proactive in the governance and oversight of this. We do consider that some improvements were made but did not consider that they went far enough.

Regulation 10 Dignity
May/June 2023
Interactions
Allegation 7 - Not Found Proved
The Appellant failed to ensure that there were meaningful and sufficient staff interactions with service users.

228. The Tribunal were not satisfied that this allegation was sufficiently made out. We noted that SUDD vocalises noises as a form of communication and there was no evidence that any distress was caused. We considered that the description of what was observed was vague and therefore we did not consider that there was sufficient information to satisfy us that the allegation was made out.

Dignity/ Privacy
Allegation 6 - Not Found Proved
The Appellant failed to ensure service users were treated in a respectful and dignified way.

229. The Tribunal were persuaded that this did occur but given that it occurred only once and there was no repetition in 2024, we considered that it was sufficiently low-level not to constitute a breach of the regulation.

Allegation 8 (a-c) - Not Found Proved
The Appellant failed to ensure that staff supported service users in a dignified way.

230. Though the Tribunal accepts that the act of syringing liquid medicine into SUD's mouth and applying cream to their feet did occur, we did not consider that this was a breach of the regulation. We reminded ourselves that this was SUD's home, and we did not think it was undignified for them to receive care in the lounge area of their own home.

Allegation 9 - **Not Found Proved**
The Appellant failed to ensure that staff sleeping arrangements were dignified for service users.

231. The Tribunal considered that this was a breach of the regulation which had been mitigated and was no longer ongoing. We bore in mind the challenges that occur around service users' homes and that this was a one bedroom flat. We noted that this had been addressed and was no longer an issue identified in the 2024 inspection and therefore was no longer an ongoing breach.

Language in care notes/plans
Allegation 10 (a – i) - Not Found Proved
The Appellant failed to ensure that staff spoke with service users and recorded care notes about service users in a respectful and dignified manner.

232. The Tribunal accepted that the use of words such as “shit” in care notes was inappropriate, but we also bore in mind that some of the staff did not have English as a first or main language, so we did not consider that this was sufficient for a breach. We did not consider that there was sufficient evidence to persuade us that the use of the “diaper” was inappropriate, due to the way it is used in different contexts. For example in other English-speaking countries (USA) it may be used to describe adult sanitary pads. Further, we noted that the issue in respect of referring to matters relating to sexuality, though we accepted that this was inappropriate, it had been resolved and there was no repetition in 2024. We were not persuaded that this was an ongoing breach. Further, we did not consider there was sufficient evidence before us to persuade us that the staff did view service users’ settings as their homes.

232. We accepted the Appellant’s explanation that the term “home leave” was never meant to have negative connotations. Service users have a home with the Appellant, but they also have a family home.

233. In respect of the incorrect name used in the risk assessment, we noted that the Appellant stated that the risk assessment was immediately updated and had not been used throughout the risk assessment; we were advised that the correct Service Users’ name was at the top of the risk assessment by the Appellant as the document provided to the Tribunal was heavily redacted and therefore we accepted the Appellant’s submissions in respect of the document. The Appellant also accepted that the use of the term “fake” was inappropriate and they had corrected it.

234. We also agreed that the use of the term “baby monitor” was not a breach of the regulation as this is how the product is described online and, in the notes, it was used to describe the equipment being used; nor were we persuaded that the observations around dusting were sufficient to constitute a breach. Further, that “challenging behaviour”, a term that was regularly used in settings but now out of favour with current thinking, was not sufficient to constitute a breach. The Tribunal noted that one of the CQC inspectors used the term ‘challenging behaviour’ whilst giving their oral evidence.

Choice
Allegation 11 (a – c) - Not Found Proved
The Appellant failed to encourage service users to maintain a healthy diet or respecting service users’ choices with meals.

235. The Respondent refers to one incident and therefore there was no evidence to suggest that this was of widespread concern. The Tribunal accepted the evidence of the Appellant that some service users are resistant to change. They explained how they undertake shopping and menu planning with service users every week, where they are encouraged to consider maintaining a healthy diet.

236. Further, we accepted that SUD is able to communicate his needs and wishes to staff and is also able to help himself to food in the fridge or cupboards when he wishes. It is noted that SUD will refuse foods and indicate if they do not like the food presented. We also noted that the Appellant had taken the opportunity to review care plans and were following the “Healthier Me” guidance. Therefore, we did not consider that this was a breach of the regulations.

Regulation 19 Fit and proper person
Unsafe recruitment practices
Allegation 32 (a-g) - Found proved
The Appellant failed to operate safe recruitment practices.

237. The Tribunal was concerned regarding the deficiencies in the recruitment practices as this was fundamental to ensuring safeguarding for service users and staff members had the appropriate competency for their role.

238. Appellant accepts that there were some gaps within its employment records and an additional resource was required to manage HR/ employment records.
The Tribunal were advised that the Appellant recruited a HR Manager in August 2023 who has proven to be instrumental in the review and ongoing maintenance of HR records.

239. The Appellant maintained that all HR records had been reviewed with the aim of rectifying any gaps, with active enquiries being made. Since her appointment in August 2023, the HR Manager had begun to audit the staff files to bring them all up to date. The Appellant stated that the HR Manager had completed all the gaps; however, several concerns /gaps were still identified at the April 2024 inspection some 8 months after the HR manager appointment. When asked by the inspector in April 2024, the HR Manager was unable to show records or documents that aligned with her audit, saying “that’s the problem, I hold all of the information in my head”.

240. The Tribunal was aware that the HR manager was no longer in place and we were not persuaded that this had been resolved, due to the continued concerns raised at April 2024 inspection and as the vacant HR Manager position was yet to be filled. We considered that these were serious oversights, and that errors occurred with several staff members records, in differing ways (such as a lack of detail in their previous employment record, unexplained gaps in their employment record, no references on file, the only reference on file being from a family member and not a former employer/independent referee).

Allegation 70 – Found Proved
5 staffing files were incomplete placing people at risk of harm.

241. This was accepted by the Appellant who stated that the staffing files were now completed and therefore the risk was no longer ongoing.

242. However, the Tribunal were concerned that these were a repetition of inadequacies that had been identified in 2023. We noted that Inspector Steele gave evidence to suggest that the auditing spreadsheet viewed by Inspector Kavanagh (who had supported her in the inspection at Head Office) had discrepancies and that the spreadsheet did not align with the records viewed. There was no evidence before us to demonstrate that these gaps had been identified through the Appellant’s own means. There was an example of when a reference had not been sought and that this with when the HR manager was in place. Therefore, we were not persuaded that the risk had been mitigated and it remained ongoing.

Allegation 71 – Found Proved

Failure to ensure safe recruitment procedures were in place and effective: re SM's 29 and/or 60 and/or 61 and/or 62 and/or 63.

242. The Tribunal was concerned regarding the deficiencies in the recruitment practices as this was fundamental to ensuring safeguarding for service users and staff members had the appropriate competency for their role. The Appellant accepted that these 5 staff files were incomplete but that all HR records had been reviewed with the aim of rectifying any gaps, with active enquiries being made. Since her appointment in August 2023, the HR Manager had begun to audit the staff files to bring them all up to date. The Appellant stated that the HR Manager had completed all the gaps; however, several concerns /gaps were still identified at the April 2024 inspection some 8 months after the HR manager appointment.

243. The HR Manager was asked about gaps that were found in the employment history for SM60 between 1996-2011, with no recorded reason for this. She said they had been followed up but was unable to remember on what date SM60 had to provide the information by. She was unable to show on the recruitment spreadsheet (auditing form) where the gap had been identified or if any action had been completed to address this.

244. A similar gap had been found in the employment history for SM61 from 2020 to 2023, with no recorded reason. The HR manager told the inspector she had requested the information that morning; however, SM61 had already been offered the job by the Appellant and had started work that day.

245. Issues with references received for SM61 and SM62 were also noted. These included a reference received but not from the most recent employer; a reference received from an employer not recorded on the employment history; no reference received from a recent employer which involved care work, instead 2 character references had been accepted.

246. The Tribunal was aware that the HR manager was no longer in place, and we were not persuaded that this had been resolved, due to the continued concerns raised and as the vacant HR Manager position was yet to be filled. We considered that these were major oversights and that this with when the HR Manager was in place. Therefore, we were not persuaded that the risk had been mitigated and it remained ongoing. We considered that allegations 70 and 71 were borne out of the same facts and therefore we considered this as one allegation.

Right Support, Right Care, Right Culture (RSRCRC).
Allegation 1 - Not determined
The Appellant has failed to meet the requirements of the statutory guidance Right Support, Right Care, Right Culture (RSRCRC).

247. The guidance directs and supports providers to ensure people with a learning disability and autistic people live a meaningful life supporting them to maximise their choices, control and independence leading to confident and an empowered lifestyle. The Respondent state that the Appellant is not meeting the guidance.

248. The Appellant does not accept that it failed to meet this statutory guidance. However, they state that they have made further improvements which support people with a learning disability and/or Autism and that the principles of RSRCRC are upheld and embedded within the service.

249. The Appellant outlined several ways in which they demonstrate this including: asking all staff to read and sign service user care plans to signify their understanding; by encouraging service users to make choices about their life so they feel empowered and in control; by creating a routine that is individualised to the service user, which is particularly important to their service users; by providing staff with training on how to uphold RSRCRC; and by auditing care plans to ensure that all service users are supported in a way that maximises their choice, control and independence.

The Tribunal had identified breaches in Regulations 9, 12, 13, 17, 18 and 19, which does not accord with the principles of the guidance being upheld. However, we did not consider that it was appropriate for us to determine this point as we had not been referred to any specific guidance, it was very widely and generally worded and nor was this a breach of a specific regulation in of itself.

Conditions

250. Having considered the number of breaches that had been found proved, alongside the fact that the Tribunal has not been persuaded that a large number have been mitigated and remain as ongoing risks.

251. We bore in mind that Ms Jones spoke confidently of the progress she feels the Appellant has made. However, it is noted as mentioned above that on her most recent visit to the Appellant's service, she did not observe any service users as they were not in their homes. Whilst Ms Jones felt this was a positive which demonstrates Service Users were out at activities, the Tribunal did approach her assessment with caution as indeed Ms Jones has not recently witnessed 'care' being provided to Service Users. We also considered that Ms Jones was quite fixated in her view in respect of the CQC and what was in her view, a hyper critical approach.

252. The Respondent stated that it is also an important feature of this case that the Service Users are not necessarily at risk of losing their homes should the Appellant's registration be cancelled. Each service user has their own tenancy with a landlord, which is different to the Appellant (although it is understood that Ms Mitchell is in fact the Landlord of several of the settings, this is a separate legal entity from the Appellant (provider of care)). As such, where concern has been expressed in regard to the potential impact upon Service Users, should they be required to move home (in the main a concern expressed by their parents) it does not follow that this will in fact be the case following cancellation. In any event, such potential impact is considered by the Respondent within the decision-making process and if a move is necessitated, this will be carefully managed by professionals trained in doing just that. Mr Simon Abbott explained that the matter was 'with the lawyers'. He said this was not a settled legal position and that a new service provider could be 'dropped in' to take over care.

253. However, we reminded ourselves of our role in ensuring that risk was mitigated.

We therefore considered what conditions may be put place. However, we accepted that the issues at the Appellant's service are wide ranging and systemic. Whilst it is conceded by the CQC that some improvements had been made, the Tribunal remained concerned that the Appellant remained dependant on the assistance of third-party organisations to identify issues for improvements to be made despite having had assistance for quite some time.

254. We accepted that any potential conditions requiring the continued engagement from third parties, or reporting to the CQC, would substitute the role of the Nominated Individual and Registered Managers whose role it is to safely and effectively manage the Service, and rather than assisting them in moving forward with improvement, retain their reliance on such supportive measures.

255. A condition to restrict the size of the Service was rejected as not viable by Ms Jones who observed that the likelihood would be that the Service would remain with the most complex Service Users, and considered this would not be of assistance. Ms Jones also expressed doubts about the merit of a requirement for a second independent consultancy firm to assess the Appellant, noting that this would likely become a contest between consultancy firms rather than a legitimate assessment of the Appellant and the Tribunal considered that this would become unworkable.

256. Miss Mitchell has in her statement suggested that a suitable condition would be a restriction on admissions but as pointed out by the Respondent, Surrey County Council have had a suspension on submissions for over 12 months and the Appellant themselves had provided an undertaking to the Respondent not to admit new service users since June 2023. Despite this, the Appellant has failed to drive and sustain improvements at the service, in order to satisfy the Tribunal that they will reach compliance with the Regulations.

257. Ms Mitchell further suggests that a suitable condition would be a requirement to undertake training on medications and accident/incidents. However, such training should be arranged by the Appellant in any event.

258. The Respondent explained that Mr Abbott confirmed that such training had already taken place with the Local Authority and the quality assurance team of the same continue to provide support and guidance with risk management and care planning. Notwithstanding such training and support, improvements have plainly not been made. Accordingly, the Tribunal could not find any workable conditions which would suitably manage the Appellant to compliance with the Regulations.

259. The Appellant's service has grown significantly between the 2019 inspection and the 2023 and 2024 inspections. Notably, this growth has taken place over an extremely difficult period spanning both Brexit and a global pandemic. However, we considered that the failures as mentioned above were not attributable these difficulties, as there were at times many repeated breaches on fundamental requirements both in 2023 and 2024 and were more attributable to widespread systemic failures and inadequate oversight.

260. Since June 2023 the Appellant has not been able to make and sustain improvements at the Service to ensure regulatory compliance. The Appellant has

been unable to present a cohesion picture of compliance. Systems and improvements have either not been sufficiently demonstrated or have been demonstrated not to be sufficient.

261. We recognise that in some cases the imposition of conditions may have the clear potential to address the public interest so rendering refusal disproportionate. In our view, the conditions that have been proposed (and/or any that we could devise) would not address the true substance of the public interest considerations in this appeal in any meaningful way. Conditions would, in our view, amount to "tinkering around the edges" and would utterly fail to recognise, or afford any or any adequate weight to, the public interest principles which underpin the national guidance, and which are in line with statutory objectives of the Respondent.

262. In light of this, the Tribunal concludes that the decision to cancel the Appellant's registration has been made, reasonably and proportionately having regard to the inspection history, based on the Appellant's continued and persistent failures to comply with the regulations.

Conclusion

263. 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 regulatory function, we find that the decision was (and remains) fair, reasonable and proportionate.

Decision

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

Judge Iman

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

Date issued: 18 March 2025