First-tier Tribunal Care Standards

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

2024-01197.EA
Neutral Citation Number: [2025] UKFTT 00548 (HESC)

Hearing held at the Royal Courts of Justice
on 3-7 March 2025
(with a deliberation day on 15 April 2025)

BEFORE
Simon Lewis (Judge)
Ms L Jacobs (Specialist Member)
Ms J Everitt (Specialist Member)

BETWEEN

WESTHOPE LIMITED

Appellant

- and -

CARE QUALITY COMMISSION

Respondent

DECISION

INTRODUCTION

The Appeal

1. This is not a simple case. The appeal ("the Appeal") is brought in relation to a decision by the Respondent ("the Decision"), set out in a written notice of decision dated 9 July 2024 ("the Notice of Decision"), to vary a condition of the Appellant's registration as a service provider, so that it no longer be authorised to carry on the relevant regulated activity (accommodation for persons who require nursing or personal care) at one of three locations: a residential home for up to 7 people with autism or learning disability or similar ("the Location"). The Location is known as Westhope Place. The other two locations are known as Westhope Lodge and Westhope Mews. All three are in the town of Horsham. As set out further below, though, the Appellant is part of a much larger group ("the Group"). The Appeal is brought under, and relates to, the Health and Social Care Act 2008 ("the Act").

The Hearing

2. The Appeal was heard over five days in March 2025 ("the Hearing"). The Hearing was conducted in public. Although it was a hybrid hearing, all witnesses, panel members, and counsel attended each day in person. The Hearing was recorded. The Appellant was represented by Anna Wilkinson (counsel); the Respondent by Jemima Lovatt (counsel).

Evidence

Documents

3. We had before us a core bundle of documents ("the Bundle"), running to 2,697 pages electronically. The Bundle was available in both electronic and paper form. By consent, a formal report from the Respondent regarding its assessment of the Location from March 2024, was added to the Bundle. In addition, we had regard to skeleton arguments and closing written submissions from the parties.

Witness Evidence

4. We read witness statements, and heard oral evidence, from three witnesses for the Respondent and five for the Appellant. The Respondent's witnesses, in this order, were: Trudy Lockyer (CQC inspector); Sheralee Davies (CQC inspector); Jane Jewell (an CQC operations manager and manager of Ms Lockyer). The Appellant's witnesses, in this order, were: Zoe Loizou (a regional manager at the Group and, for a short period, the former interim manager at the Location); Lucy Bridger (former Director of Supported Living at the Group); Dan Svensson (former Chief Operating Officer for Independent Living at the Group); Pauline Paterson (Director of Quality and Regulation at the Group); and Heidi Smoult (a consultant engaged by the Group). Three witnesses provided supplementary statements: Ms Lockyer; Ms Jewell; Ms Paterson.

General Point

5. We read/heard a large amount of evidence, some of which was relatively detailed or technical. We considered all of the material evidence we read/heard, or which was otherwise brought to our attention, even if we do not refer to it expressly or in detail below. In what follows we have sought to record matters we considered to be of particular significance.

Preliminary Application

6. On or around 11 February 2025, the Appellant made a written application ("the Preliminary Application") to strike out the Respondent's response (or otherwise bar the Respondent from taking further part in the Appeal), under rule 8 of the Tribunal Procedure (Frist-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ("the Rules"), on the basis that the Respondent's response had no reasonable prospect of success. The Respondent provided written submissions, dated 19 February 2025, in opposition to the Preliminary

Application.

7. On the first day of the Hearing, having dealt with various housekeeping matters, we heard extensive oral submissions in relation to the Preliminary Application. Following deliberations, we dismissed the Preliminary Application. We gave full reasons, orally, on the morning of the second day of the Hearing, which we do not repeat in any detail here. In essence: we were far from satisfied, on the basis of the submissions and having regard to the documentary evidence before us, that the Respondent's case in response to and in opposition to the Appeal could properly be categorised as having no reasonable prospect of success; and, in our judgment, it was firmly in the interests of justice, in all the circumstances, for the Respondent to continue to participate fully in the Hearing.

Access Issue

8. The majority of the Hearing was conducted as a hybrid hearing. However, there were some technical or practical issues (e.g. problems with the national Cloud Video Platform system and/or with the availability or effectiveness of facilities and systems within the courtroom), which for limited periods meant that, despite reasonable efforts to remedy issues, people (including members of the public) would not have been able to join remotely. We were made aware of these issues impacting one individual, at certain times, who wished to observe. While that was regrettable, it was, in our view, in the interests of justice, and in line with the Rules (including the overriding objective), to proceed with the Hearing, as we ended up doing (with consent from the parties), during such periods of limited access.

Reporting Restrictions

9. At a case management hearing on 5 February 2025, an order was made to prohibit disclosure or publication of any documents in the Appeal likely to lead members of the public to identify service users or staff members of the Appellant, so as to protect their private lives in accordance with rule 14(1)(a)-(b) of the Rules ("the Rule 14 Order"). In the course of our deliberations and in the finalisation of our written decision, however, we formed a preliminary view that, while the Rule 14 Order remained justified in relation to service users, it was, having due regard to the principles of open justice and the applicable case law, probably no longer justified in relation to all staff members, or at least that it ought not be interpreted or applied as extending to the directors and senior regional managers of the Group (whether current or former) called as witnesses at the Hearing and able to give their own account to the Tribunal. We wrote to the parties on 1 May 2025 to communicate our preliminary view, propose a potential amendment to the Rule 14 Order, and provide an opportunity to raise any objection or make any further submissions on this point. The Appellant later confirmed, in writing, that it had no objection to our proposed amendment and no further submissions to make. The Respondent did not reply. In all the circumstances, we decided to amend the Rule 14 Order as follows: "The Tribunal prohibits the disclosure or publication of any documents in this appeal likely to lead members of the public to identify any service user or staff member of the Appellant (but not including any of the individuals called by the Appellant as witnesses in these proceedings), so as to protect their private lives in accordance with rule 14(1)(a)-(b) of the 2008 Rules."

RELEVANT PRINCIPLES

The Act

10. The Respondent is the regulator of health and social care in England. It was established by the Act. All references to section numbers in this document are to sections in the Act unless otherwise indicated. Although we do not set out in full the relevant provisions of the Act below, we had careful regard to them, and the particular wording of them, in full.

11. Section 3(1) provides that the Respondent's "main objective" in performing its functions is to "protect and promote the health, safety and welfare of people who use health and social care services". Section 3(2) provides that the Respondent is to perform its functions for the general purpose of encouraging: improvement of health and social care services; provision of health and social care services in a way that focuses on the needs and experiences of service users; efficient and effective use of resources in the provision of health and social care services.

12. Section 4(1) sets out matters the Respondent must, in performing its functions, have regard to. They include, at section 4(1)(e), with emphasis added by us: "the need to ensure that action by [the Respondent] in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed". While section 4(1)(e) is expressly connected to "action" by the Respondent, and is the provision that the parties generally tended to focus on, the list also includes: views expressed by or on behalf of the public; experiences of service users and family/friends; the need to protect and promote the rights of service users; relevant developments in approaches to regulatory action; and best practice in organisations providing comparable services to the Respondent (including principles relating to the transparency, accountability, and consistency of regulatory action).

13. Under section 12(5), the Respondent may at any time "vary or remove any condition for the time being in force in relation to a person's registration as a service provider", or impose any additional condition.

14. Section 19 prohibits an application by a service provider for the variation of a condition if the Respondent has already issued a notice of proposal to make a variation which would have substantially the same effect as the variation sought.

15. Under section 20, the Secretary of State is empowered to make regulations. The regulations made under this section, and which are relevant to the Appeal, are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"). All references in this document to regulation numbers are to the Regulations, unless otherwise indicated.

16. Sections 26-28 set out procedural requirements in relation to the notification of various decisions by the Respondent. In essence, at least so far as is relevant to the Appeal: if minded to vary or remove a relevant condition, the Respondent is required, first, to issue a written notice of proposal; the Appellant would then have

an opportunity, within 28 days, to provide written representations on any matter it wished to dispute; the Respondent would then, if still minded (having taken account of any representations) to adopt the steps set out in the notice of proposal, confirm the relevant decision by a written notice of decision.

17. Section 32 provides the right of appeal, to the Tribunal, against certain decisions by the Respondent. On such an appeal, the Tribunal may, under section 32(3), confirm the relevant decision or direct that it is to cease to have effect. The Tribunal also has power, under section 32(6), to make directions in relation to (discretionary) conditions: varying them, adding them, etc.

The Regulations

18. Part 3 of the Regulations sets out what are referred to as the "Fundamental Standards" which registered service providers must comply with when carrying on a relevant regulated activity. The relevant regulations for the purposes of the Appeal are regulations 9, 12, 13, 17. Regulation 9 relates to "person-centred care"; regulation 12 to "safe care and treatment"; regulation 13 to "safeguarding service users from abuse and improper treatment"; and regulation 17 to "good governance".

Policy Documents

19. We were provided with various policy, procedure or guidance documents. These included the relevant policy relating to the Respondent's enforcement approach ("the Enforcement Policy") and an associated guidance document, referred to expressly within the Enforcement Policy, relating to what is described as the Respondent's "enforcement decision tree" ("the Decision Tree"). On the evidence and in all the circumstances, despite only having the status of policy or guidance documents, we considered these to be significant documents that we should have particular regard to. The most relevant parts of the Enforcement Policy and the Decision Tree are referred to in more detail further below.

Wider Principles

20. The Appeal is to be dealt with "de novo", rather than, for example, by way of a review of the Respondent's decision. In other words, the Tribunal is to consider the matter afresh and independently; "stepping into shoes", as it were, of the Respondent's key decision-maker to make the relevant decision itself.

21. Importantly, the Tribunal is required to make the relevant decision as at the time of the relevant hearing before it; rather than, for example, as at the time that the Respondent made the decision being appealed. Moreover, the Tribunal, can and should have regard to all relevant evidence that, by that later point in time, is properly before it.

22. It is common ground, and consistent with the case law (e.g. *Care Management Group Ltd v CQC* [2017], *The Care Centric Group Limited v CQC* [2024]), that the burden, in the Appeal, is on the Respondent. It must establish the facts on which it relies (in relation to any material breach of the Regulations for example)

and, perhaps more relevantly in this particular case, that it would be proportionate, at the time of the Hearing, to make the decision it made and now seeks to defend. The applicable standard of proof is the civil standard: i.e. whether, on the balance of probabilities, the relevant thing it more likely than not.

THE POSITIONS OF THE PARTIES

The Appellant

23. In a nutshell, the Appellant submits that, although there had been material breaches of the Regulations at the time of the Respondent's on-site inspection visits in March 2024, it had gone on to make significant improvements and, moreover, had then stopped providing any relevant services from the Location. As a consequence, the Appellant submits that, irrespective of the position at any relevant earlier point in time, there is now, as at the date of the Hearing, no longer any sufficient justification, objectively, for the Decision being a proportionate regulatory intervention. The Appellant invites us to direct that the Decision shall cease to have effect.

The Respondent

24. In a nutshell, the Respondent submits that: the material breaches were serious; the Appellant has failed to demonstrate that any subsequent improvements were sufficient to "remedy the breaches" or to "address all of the regulatory shortfalls"; and there continues, at the date of the Hearing, to be a sufficient justification, objectively, to maintain the Decision. It has little confidence in the Appellant's ability to provide care that would be compliant with the Regulations, should it choose to re-open and provide relevant regulated activities from the Location (and there remains, it submits, a real risk of that). The Respondent therefore invites us to dismiss the Appeal, notwithstanding the current status of the Location as "closed". No secondary or alternative position was advanced by the Respondent (nor, indeed, by the Appellant).

CHRONOLOGY

25. It is helpful, at this point, to set out a broad chronology of key matters. This is a case where the chronology is, in our view, particularly important. There was little if any material dispute, between the parties, in relation to the broad chronology. Where there was any such dispute, our findings are set out in this section.

26. In 2010-2011, the Appellant first registered with the Respondent to carry on regulated activity (accommodation for persons who require nursing or personal care), with a condition that such activity may only be carried on at the three locations referred to above. Another condition, albeit one less relevant to the Appeal, was that it must not provide nursing care under accommodation for persons who require personal or nursing care at any of the locations.

27. In 2018, the Location was rated by the Respondent as "good". More specifically, it was rated as "good" in all five domains, apart from the "well-led" domain for which it was rated as "requires improvement". That means it was rated "good" in

relation to whether the service was “safe”, “effective”, “caring”, and “responsive”.

28. In early 2020, there was an acquisition of the Appellant by a business known as Accomplish Group. In July 2022, there was a merger between Accomplish Group and the Group (i.e. a business known as Keys Group). The Appellant is therefore part of, and effectively controlled by, a larger and wider group; and was at all (or, at least, most) material times. It is helpful to set out some further relevant facts in relation to the Group and its connection to the Appellant. In broad terms, the Group, at all material times, had three main divisions: adult residential; children’s residential; and, more relevant to the Appeal, independent living and activities, which included supporting living and supported accommodation. Mr Svensson, a former member of the Group’s top leadership team, was responsible for independent living and activities. Ms Bridger, who oversaw a network of regional managers and managers of individual services, reported to him. That division had around 22 registered services and 1,400 employees. The Group has corporate support functions such as HR, finance, estates, legal: overall, it employs around 7,000 people and supports over 2,000 people across 300 services (about 67 of which are regulated by CQC). We accept the evidence from Ms Paterson, a director, that across the Group over 80% of CQC-regulated services are (at the time of her statement) rated “good” or “outstanding”.

29. On 5 March 2024, one of the seven service users at the Location (“SU3”) died. Up to that point, we find, on the evidence, that the Group’s leadership did not consider the Location (or the two other locations operated by the Appellant) to be a place where there were serious issues (or, at Mr Svensson put it, “reg flags”) in terms of quality, safety, management, etc. The Group’s leadership had been, we find, more focused on other areas of its business portfolio. The death of SU3 changed things. It triggered much closer scrutiny of the Location: from the Group and various external bodies (including the Respondent). That scrutiny, we find, led to the identification of some considerable issues at the Location relating to quality, safety, and other aspects of performance and leadership. As indicated further below, we make no findings about the actual cause of death, or the degree of any contribution or culpability that may (or may not) be attributable to the Appellant’s acts or omissions. Neither party focused on such matters in their submissions or evidence. Alternative processes – beginning, it seems, with an inquest scheduled for or around May 2025 – will focus on such things. We simply record that SU3’s death is believed, by various individuals/organisations, to potentially relate to a choking incident while residing at the Location.

30. On 13 March 2024, shortly after the death of SU3, the Appellant was identified as a “provider of concern” by West Sussex County Council (“the Council”). That initiated a provider of concern process, which was followed by the Council and which the Appellant (with considerable involvement from the Group) engaged in.

31. On or around 15 March 2024, Ms Bridger started, in effect, to focus full-time at the Location.

32. On 19 March 2024 (or, if we are wrong on that, 18 March), the Respondent completed the first of two on-site inspections at the Location. The second took place on 21 March 2024. Following those inspections, the Respondent rated the

Location as “inadequate” overall, although the formal report relating to the same was not produced until August 2024. More specifically, per the formal report, the Location was rated as: “inadequate” in relation to the “safe” and “well-led” domains; “requires improvement” in relation to the “effective” and “caring” domains; but “good” in relation to the “responsive” domain.

33. On 22 March 2024, following discussions, the Appellant (or, in practice, the Group, and in particular Mr Svensson, on its behalf) gave formal written notice to the Council of its “decision to close” the Location and, in the same letter, gave the necessary 12 weeks’ notice in relation to the four commissioned placements at the Location (meaning that the final day of such placements would, in principle, be 13 June 2024 at the latest). In the letter, the Appellant also expressly stated, among other things, that it would inform the Respondent, and would work in “full partnership” with the Council to make the transition for residents as smooth as possible. We accept the evidence from the Appellant that the decision, itself, was made on or around 19 March 2024 by executive leaders at the Group.

34. On 22 March 2024, the Group put Ms Loizou in place as interim manager at the Location (transferring her from her substantive role), in the ongoing absence of the substantive regional manager (in relation to a serious long-term health issue) and in circumstances where the previous (acting) manager had been suspended pending an investigation. Ms Loizou started to work with Ms Bridger.

35. On 25 March 2024, Mr Svensson gave similar notice in writing to the two other relevant councils: Surrey County Council, in relation to one service user; and the London Borough of Sutton, in relation to the other service user.

36. On 25 March 2024, Mr Svensson also wrote to the Respondent on behalf of the Appellant/Group. In the first line, he informed the Respondent that a “decision” had been taken “to close” the Location. He listed a range of immediate measures, designed to safeguard residents and improve the service, and referred to an “action plan” which he said would be kept under review and shared weekly. He stated that, notwithstanding the decision to close, improvements would continue to be implemented at the Location, and other services across the organisation. He highlighted some key reasons why he said the decision to close the Location had been made. He stated that the relevant local authorities had been duly notified and stated that the Appellant/Group would work in partnership with them to minimise disruption to service users. Among other things, he expressly stated that the Appellant/Group will “begin the process of deregistering the service in due course and in consultation with CQC and the stakeholder agencies”.

37. On 5 April 2024, the Council, as part of its provider of concern process, carried out an on-site (contract quality) monitoring visit at the Location. A report, following the visit, is in the Bundle. The visit focused, to a considerable extent, on the improvement plan the Appellant was by then in the process of implementing. As a consequence, the Council, we find, considered areas such as those relating to: safe management of diet and nutritional needs; staff knowledge and competence in relation to safety; management oversight, audits and governance. In the course of the visit, the Council considered evidenced relating to service user files, support plans and risk assessments, and medication management records. The

Council reached the following main conclusions on the evidence then before it: (1) the implementation plan was being implemented, as planned; (2) the Location had, by then, completed 45 of 67 actions listed; and (3) the leadership team that was by then on site had "begun" to make "substantial improvements" to the service. Some actions were agreed (e.g. to update support plans and risk assessments) and a further monitoring visit was scheduled for 8 May 2024.

38. On 9 April 2024, a management review meeting ("MRM") was conducted by the Respondent. At the MRM, the Respondent assessed the seriousness of the material breaches using the Decision Tree.

39. On 9-10 April 2024, a quality benchmark audit was conducted, in relation to the Location, by the quality manager responsible for carrying out internal audits at the Group. The Location was assessed, in our view, in relation to broadly similar areas, domains, or "lines of enquiry" to those considered by the Respondent (e.g. safe, well-led, person-centred, culture, compliance, medication, people supported). Overall, the Location was rated "inadequate", with a score of 48%.

40. On 17 April 2024, a multi-agency meeting took place.

41. On 20 April 2024, and at other earlier and later points, the Appellant sent a copy of the improvement/action plan to the Respondent.

42. On 24 April 2024, the Respondent issued the relevant notice of proposal ("the Notice of Proposal"), to vary the Appellant's conditions so that it no longer be authorised to carry on the relevant regulated activity at the Location, setting out its reasoning/grounds in some detail. The headline reason was put this way: "We are making this proposal because the [relevant] regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements". The conclusion was put this way: the Respondent "is of the opinion that the most appropriate and proportionate response to the above cited failures is to propose to vary a condition of your registration". The Respondent, in the main body of the Notice of Proposal, set out the evidence it relied on, in relation to each of the Regulations it considered to be relevant/breached. A relatively large number of documents were attached in support. The Appellant was given 28 days to provide representations if it did not agree.

43. On 30 April 2024, a further quality benchmark audit was conducted by or on the Appellant's behalf at the Location. On this occasion, the Location was rated as "requires improvement", rather than "inadequate", and had improved its overall score to 63% (from the previous 48%).

44. On 30 April and 1 May 2024, the Respondent carried out an on-site inspection of one of the two other locations, Westhorpe Lodge, rating it "requires improvement" overall (but not, we note, "inadequate"). No enforcement action was or has been taken in relation to Westhorpe Lodge following that inspection/assessment. At its previous inspection/assessment, in 2019, the Respondent rated it "good".

45. On 8 or 9 May 2024, the Council conducted its second monitoring visit at the Location. It produced a formal addendum report, recording its findings. It found

that support plans and risk assessments had, in line with the actions agreed after the first visit, been "completed". Among other things, it considered, and appears to have accepted, the benchmark audit completed on 30 April 2024. It considered "health and safety" and referred, for example, to a health and safety audit scoring 84% in February 2024. The following conclusions were recorded: (1) further evidence had been found that the improvement plan was being implemented as planned; (2) the on-site leadership had "continued to make substantial improvements" to the service, "addressing all areas" of the improvement plan; and (3) there were "no concerns raised because of this visit" and the report "successfully concludes the monitoring exercise".

46. On 16 May 2024, the Appellant made a formal application, to the Respondent, to vary the terms of its registration so that it be no longer authorised to carry on relevant regulated activity at the Location. In other words: it sought a similar outcome to that proposed by the Respondent, but via voluntary application rather than by formal regulatory action from the Respondent. It is clear to us, as indicated in our oral judgment dismissing the Preliminary Application, that, given the express prohibitory provision in section 19 of the Act, the application made on 16 May 2024 ought not to have been granted by the Respondent.

47. On 20 May 2024, the Appellant effectively ceased any relevant operations (i.e. any relevant regulated activity) at the Location, with all six of the relevant services users having by then been moved to alternative locations/providers. There is an email to that effect, of that date, from Mr Svensson to the Respondent.

48. On 21 May 2024, the Appellant's representations dated 20 May 2024 ("the Representations"), with approximately 200 supporting documents, were received by the Respondent.

49. On 22 May 2024, the Respondent then (erroneously) issued a notice of decision, purporting to grant the Appellant's 16 May application to vary the registration, and issued a replacement certificate of registration with the Location removed.

50. On 11 June and 13 June 2024, an on-site inspection of Westhope Mews was carried out by the Respondent, with its being rated "requires improvement" (but not, we note, "inadequate"). No enforcement action was or has been taken in relation to Westhorpe Mews following that inspection/assessment. At its previous inspection/assessment, in 2019, the Respondent rated it "good".

51. On 5 July 2024, the Respondent sent an email to the Appellant to state that its application to remove the Location had now in fact been "rejected" (correcting, as it were, the erroneous purported acceptance of 22 May 2024). At or around this point in time, the Location was formally re-instated on the public register.

52. On 9 July 2024, the Respondent issued the Notice of Decision. It reiterated, as a headline reason, that its "inspection of [the Location] on 18 and 21 March 2024 found the regulated activity stated above is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements." It added that, having considered the Representations, the Appellant had, in its view, "not demonstrated" that its "concerns have been addressed and that you are carrying

out the regulated activity in accordance with the relevant requirements at this time". It added that, pursuant to section 25(1) of the Act, the Appellant was "required to demonstrate" it has "considered and applied" guidance on meeting the Regulations. It referred to the "breaches" identified in the Notice of Proposal, before setting out the key breaches, as it saw them, under each respective regulation, and explaining why the Appellant had not, in essence, evidenced sufficient improvement. It concluded that the Notice of Proposal was and "remains" both appropriate and proportionate.

53. On 2 August 2024, the Appeal was lodged.

54. On 15 August 2024, the Respondent published its final report confirming that the Location had been rated as "inadequate".

FURTHER ANALYSIS AND CONCLUSIONS WITH REASONS

Summary

55. In light of all of the relevant evidence before us, including that not available to the Respondent at the time it made the Decision, we have concluded that the Decision is not, now, proportionate in all the circumstances.

Reasoning

A case turning on its own facts

56. This case has been considered, carefully, on its own unique facts and individual merits. The outcome, and the reasoning underpinning it, refers to this case only and should not be taken to set up any general principles.

Key advantage for the Tribunal

57. We had a significant and important advantage over the Respondent's relevant decision-maker. We had all of the relevant written material he/she had but, in addition, all of the written and oral evidence from the Appellant's witnesses (and indeed from all of the Respondent's witnesses too).

The strength of the Appellant's oral evidence before us

58. In broad terms, we thought that the Appellant's combined body of evidence – supplemented powerfully, as we judge it was, by oral evidence from the various witnesses on its behalf – was, overall, reliable and supportive of the core position advanced by the Appellant. We placed a substantial degree of weight on it.

59. We considered, to take a standout example, the evidence of Mr Svensson to be highly credible and persuasive. He was in a very senior position at the Group, at the material time, and had a good grasp of the reality on the ground at the Location at material times. He has a strong background in the health and care sector: 35 years, as a front-line practitioner and then as a leader. We accept his evidence that, from the point he became aware the Appellant had become a

provider of concern around 13 March 2024, he helped oversee an intensive and extensive intervention (chairing very regular meetings), designed to ensure oversight, support and improvement at the Location. We broadly accept his evidence, supported as it is by other witnesses, about actions taken under the improvement plan (including those summarised at paragraph 28 of his statement) and that those efforts continued despite the relatively early decision to effectively close the Location. We accept his evidence, supported again as it is by others and/or contemporaneous documents, that the decision to bring to an end the relevant regulated activity at the Location was genuine and final. We accept his evidence about the reasons for the decision: that, although there was sufficient capability within the Group to make the necessary improvements, there were practical/operational challenges at the time (including key absences and vacancies, and difficulties recruiting staff) which, on balance, made a carefully-managed closure a more pragmatic option. We accept his evidence about the care taken to work collaboratively with partners, such as councils, to re-locate service users to appropriate places and manage those transitions well (and the reasons for not giving a firm date about the "closure" immediately to CQC). Mr Svensson was adamant that, by or around 5 May 2024, if not before, the service provided at the Location was safe, following substantial improvement.

60. We were impressed with all of the Appellant's witnesses. Ms Loizou has well over 10 years of relevant experience in various roles within the care sector. She was candid in accepting that, on her arrival at the Location, there were significant issues. In broad terms, we accept her evidence about the changes she then helped to make, personally and/or with Ms Bridger, on the ground, in the weeks following her re-deployment, in relation to: medication management; fire risk planning; positive behavioural support; risk assessments; guidance relating to speech and language therapy ("SaLT"); reviews relating to deprivation of liberty safeguards ("DoLS"); etc. She accepted that the improvements were not fully implemented and/or fully embedded by the time the Location closed. We noted her evidence when challenged on there being only limited evidence presented to CQC in relation to (improved/compliant) medication administration records ("MAR") sheets: she indicated that, in fact, they had had a significant number of them. We accept her evidence, supported by colleagues such as Mr Svensson, that service users were moved to alternative places with care, thought and compassion. Importantly: Ms Loizou, we accept, spent a lot of time at the Location, at the material time, being there for very long days, 4-5 days a week.

61. Ms Bridger has good experience working, and is well-qualified, in the care sector. She was candid in being critical of the situation at the Location, and the various challenges, at the time of her re-deployment. She worked with Mr Svensson and others to create the improvement plan. We accept her evidence in relation to a range of improvements made by her and colleagues such as Ms Loizou (and note the consistency with Ms Loizou's account). She was candid in relation their collective inability, by the time of the two on-site inspections in mid-March, to demonstrate to the Respondent improvements she accepts were necessary. She accepted it would not have been possible to evidence that all changes were fully embedded during the material time before the Location closed. We accept her evidence, though, that she took on board the (reasonably detailed) feedback provided orally, and factored it into the ongoing implementation of the plan. We

accept she was on the call on 19 March 2024 at which the decision to close was made, and note her evidence on the reasons is consistent with Mr Svensson's. We noted that, when asked how the issues at the Location had "slipped through the net" (in the sense of not being picked up on adequately by the systems previously in place), she said "she had asked myself that for the last 5 months", adding that she "very much trusted" the management team and systems in place at the time. If Ms Bridger was a little vague in her evidence at times, we consider that likely to be because it related to detailed matters quite some time ago, and because she left her employment in July 2024.

62. Ms Paterson has worked in health and social care for over 30 years, starting as a care assistant, then working as a qualified nurse, then as a manager, etc. She retains her nursing registration (and, as such, will be subject to professional regulations and obligations). She is now a senior director at the Group. She was candid about the serious issues which existed before the interventions. She considered, on reflection, there to have been issues with the quality audits being conducted in relation to the Location (or, more accurately, the individual who was conducting them at that time), along with issues relating to other management in place (or absent) at the time. We accept her evidence about the timing and reasons for the decision to close. We accept that, in her view, the team continued to make real progress and improvement at the Location, in relation to the more serious issues, following that decision; she was realistic in accepting that there would always be room for further improvement. But like Mr Svensson, she was adamant that things were made safe and effective, and that service users were comfortable. She talked, as others did, about the responsiveness of the team that was put together, and how, in addition to those giving evidence, it included the CEO and other operational staff. She said, and we accept as likely, that the police were not, at present anyway, taking any action in relation to SU3's death.

63. Finally, there was the evidence of Ms Smoult. Initially, we were not sure it would assist us. She was not present at the material time; she had merely reviewed the documentary evidence. But, as it happened, and notwithstanding the suggestion from the Respondent that her experience is out-of-date or overly focused on the acute sector, we did consider her evidence helpful in certain respects. She has worked in healthcare over 25 years, initially as a midwife, before taking on more managerial roles, principally in the acute sector. She worked for CQC from 2013, including, for several years until 2021, as Deputy Chief Inspector of Hospitals, and a strategic lead for enforcement. After that, she was a chief executive of an acute hospital NHS trust until 2024. She now works as a consultant/coach. Interestingly, her written evidence was that the enforcement action set out in the Notice of Proposal may well have been proportionate at the time on the evidence before the CQC; but would not necessarily have been, due to the option of conditions. She highlighted a 34-day delay between inspection and enforcement, though, and raised serious questions about proportionality by 9 July 2024. She expressed a view it would by then have been reasonable to cease proposed enforcement action, having regard to the proper use of the Decision Tree and in light of wider enforcement policy, especially given the level of "engagement" from or on behalf of the Appellant and the reduction in risk arising from the decision to close, and that it was then no longer proportionate. She said full compliance is not required to reduce the level of enforcement following a notice of proposal:

action needs to be proportionate to risk. She talked about options for conditions (e.g. to provide updates, in relation to training, restrictions on new patients) as less-restrictive – and more proportionate – alternatives to the option selected by the Respondent. She talked, too, about the option to re-inspect.

Weakness in the Respondent's evidence before us

64. We do not wish to suggest, given the heading above, that the witnesses for the Respondent were poor witnesses in any general sense. They were not. We are entirely satisfied that they each did their best to give accurate and reliable evidence and endeavoured to assist the Tribunal. We are similarly satisfied that they will have gone about their work in relation to the Appellant in an ethical and proper way, committed to the important roles they have in protecting the interests of those using services for vulnerable adults etc. But, notwithstanding that, we did think there were some weaknesses in some significant parts of the evidence.

65. First, it seemed clear to us that we did not actually get to hear directly from the ultimate decision-maker (which, we were told, and we accept as likely, was the head of the "representations team" or similar).

66. Second, it seemed clear, as evidence was being tested during the Hearing, that the Respondent had chosen not to present, or otherwise take us directly to, relevant documentary evidence. For example, we were not provided with any minutes of the key MRM or any supporting background documents (notes of meetings or discussions etc) relating to the Decision itself. We were told that the Respondent does not normally disclose such things. In our view, such evidence was relevant and probably ought, in this particular case, to have been before us. That is not a criticism of the witnesses. We should add, for balance, that a similar point could be made of evidence from the Appellant in the Representations and/or in these proceedings (in relation to notes of, or other documents relating to, relevant meetings, or a larger sample of relevant forms or documents).

67. Third, it was clear to us that, in one specific respect, the Respondent's witnesses were unclear or confused about how the Decision Tree ought to be and/or was applied to the facts. To some extent, that may have been a result of the first or second point in the paragraphs immediately above. It may also be a reflection of the passage of time, or the fallibility of memory, or simply due to the pressure of giving evidence which can impact adversely on a witness's ability to recall things confidently. But, in the end, we were left with lowered confidence about the way the Respondent applied the facts of this case to the Decision Tree and/or how they were seeking to persuade us to do in the Hearing; and perhaps to some extent more generally, given the relative strength and consistency of the evidence presented and maintained by the Appellant.

68. More specifically, we record some observations about each witness individually. We heard from Ms Lockyer first. She provided helpful evidence in relation to relevant background and (in more detail) apparent breaches identified during on-site inspections. In relation to "post-assessment improvements", she said in her main statement that the CQC still considered there to be significant risks to service users that have "not been fully considered", relying in part on subsequent

visits to the other two locations, and that it was “evident the service could not have been brought into compliance in the time before the service closed”. She stated that “we understand” the Council’s “focus”, in relation to its visits and process, was “on moving people safely”; drawing a contrast with the focus of the Respondent on ensuring people receive safe, effective care, and that providers “can demonstrate regulatory compliance”. She said the “representations team” had found the Appellant to have “not provided sufficient evidence of improvement which resulted in the decision being adopted as [it] remained appropriate and proportionate”. She added her own view that the Decision “is still reasonable” as at the time of her statement and that the Appellant “would be free to begin providing regulated activities at [the Location] in the future should it choose to do so”. In her second statement, she responded to the Appellant’s statements, expressing views, with reasoning, that it had still failed, in essence, to “evidence” or provide “assurance” in relation to compliance. In oral evidence, she confirmed that the Respondent was not sufficiently concerned, at any initial point, for it to be “necessary” to take “urgent” action and that the decisions to issue the Notice of Proposal and the Notice of Decision were not hers (and said, at least initially, that she had no involvement in the latter). In relation to the application of the Decision Tree, in oral evidence, she said that the matter was initially being considered “at a higher level” but was “reduced” due to action being taken to mitigate risk: a lot was being done; it was “all hands to the deck”. The overall mark, in the Decision Tree, therefore, was “medium”, which was achieved by giving a “moderate” mark for “potential impact” and a “possible” mark for “likelihood”. She appeared to accept in cross-examination that by the time of the Notice of Decision, the “likelihood” was “remote”, which would reduce the overall seriousness to “low”. That said, later, in response to some questions/challenge from the panel, she appeared to change her evidence and say, “listening to the panel”, that the potential impact was actually “major”. Later, though, she agreed that any risk regarding choking would have disappeared by the time of the Decision, if there were no service users present. She said it would not be “part of the process” to go back to revisit the Location but that, when pushed, they “could” have gone back. The representations team could have asked them to revisit (but that, by then, there were no service users). She described things being “very chaotic” initially, during the visit(s), expressing a view that she thought the “main focus” was on moving people.

69. Ms Davies was another inspector (a “second inspector”) involved in supporting the inspection of the Location led by Ms Lockyer. She set out some detailed evidence supporting the conclusion that, at the time of the on-site inspections, there were numerous material breaches. She confirmed she attended the MRM on 9 April 2024, to convey/confirm relevant information, but did not make any decision. She was the lead inspector in relation to subsequent inspections at the other two locations. She drew a conclusion, as a result of those visits, that the Appellant was not taking “the opportunity to learn from the themes” raised in the assessment of the Location. Having regard to all three locations, she said in her statement that it was clear to her that the Appellant did not exercise sufficient oversight to “ensure” safe and effective care. The Location was “chaotic” during the visit, in terms of the number of people present, the level of activity, etc, in a small space. Records, at that time, were very “sparse”. The Appellant was “not likely”, in her view, to “address and embed the change of culture and practice”

required at the Location. She accepted that some things were dealt with: for example, Ms Paterson sorted out the fire concerns, rapidly and diligently. She said she was not the decision maker, and was not involved in the Notice of Decision. She moved on and had not seen the evidence. She thought that, had the Location not closed so quickly, they would have "gone back in", perhaps in 6 or 12 months; but a couple of months is generally not long enough to go back.

70. Ms Jewell made the initial decision to carry out an inspection at the Location, following a notification arising from the death of SU3 and the lack, at that time, of a registered manager in post. She confirmed that, following the first visit, it was decided that "urgent" action by the Respondent was not justified, given the apparent focus on mitigation from the Appellant and/or Council. She set out in her statement the basis for the view there had been material breaches at the time of the two visits. She accepted, in live evidence, she did not know how long such breaches had been in place. She gave evidence about the use of the Decision Tree. In her written statement, she said the breaches were assessed as "medium" seriousness overall, taking into account the actions post-inspection. She went on to say they discounted the option of a "warning notice" as it had not, at that stage, been established if there may be any criminal enforcement action in light of SU3's death (on the basis that section 29(5) effectively prevents a warning notice in such circumstances); and that they discounted conditions (e.g. in relation to monthly reporting/auditing) on the basis they could not identify any which would, in their view, be effective and sufficient. In her statement, while not being explicit, she appeared to indicate an increase in severity of enforcement action was merited, as provided for at stage 3B(5) of the Decision Tree document. She stated that she "undertook the final review" of the Notice of Proposal, having regard, it seems, to the fact that, at that time, the Appellant had not made a "voluntary application" to remove the Location and could therefore choose (despite any indication it had made to the contrary) to continue to provide the relevant service from there. She confirmed the Notice of Decision was made by the representations team (who would have had no prior involvement). That said, she confirmed that, as part of the process, she and Ms Lockyer, considered the Representations and conveyed to the representations team their view that proposed action "remained proportionate". The final decision would have been for the head of the representations team, having regard to a "recommendation" from the national representations inspector. She said the decision to grant the application to remove the Location was a mistake, given it was made too late (and, crucially, after the Notice of Proposal). In her supplemental statement, she set out why she considers the evidence from the Appellant to still be insufficient. In oral evidence, she said the "onus" was on the Appellant to prove/demonstrate compliance; and talked about getting a lot of organisations expressing – when faced with potential enforcement action – a purported intention to close a location (or similar) voluntarily, rather than a formal application. She talked about informing the public – and an obligation to inform the public of regulatory action – to aid decision-making by them. She confirmed no enforcement action was taken in relation to the other two locations operated by the Appellant.

71. The most problematic part of her evidence was in oral evidence, when she gave some inconsistent and/or confusing and/or confused accounts in relation to the Decision Tree. In live evidence, she indicated that they initially assessed overall

seriousness as “high” but then reduced it at the 3B stage. That was not consistent with her written evidence (see the paragraph above). She then seemed to change her position, again, and indicate that they decreased the potential impact to “moderate”, before indicating that she was confusing herself, but then settling on “moderate”. She said the likelihood was originally considered to be “probable” but reduced to “possible” due to the discussion about measures taken by the Appellant, resulting in a “medium” seriousness mark, which was then increased at the 3B stage. She later added that the Appellant’s action to mitigate was not taken into account when assessing potential impact but was on likelihood.

Further Context

72. As indicated, for most of the material time, the Appellant was part of a much larger group. According to the evidence before us, the Group has in general had a good regulatory history. But it is clear to us that there was a particular issue in relation to the Appellant and its cluster of three locations.

73. SU3’s death triggered a significant level of scrutiny. The facts and circumstances relating to the death were not, and are not, clear to us. Indeed, neither party appeared to wish to get into the same in any detail. We were told, and we accept as likely, that there is a separate ongoing legal process arising from and relating to it (i.e. that there is an inquest scheduled to be held, or to begin, in May 2025); but that no relevant police/criminal action is understood to be taking place. In short, we had no proper or sufficient evidential basis relating to the death, and any potential contribution to it by the Appellant, on which to focus our decision-making. To be clear: we make no findings of fact in relation to the cause of death or to any possible causal link with any relevant acts or omissions associated with the Appellant. It is clear though that, following the death, there was a sharp focus on the Location and that, when people (including CQC) looked more closely, they found relatively widespread regulatory breaches at that particular point in time.

Breaches

74. Although there was a detailed Scott Schedule (“the Schedule”) prepared earlier in the course of these proceedings, there was very little focus, if any, on that from either party in the Hearing. That may well have been because there was broad agreement – with two or three exceptions (which we do not consider material in the wider scheme of things) – in relation to its content, or at least the content relating to past breaches of the Regulations. Those exceptions were limited and, in practice, neither party developed a strong argument in relation to them. We have taken a relatively broad-brush approach to the matters referred to in the Schedule. That is not to underplay the importance of the breaches: it is merely a reflection of the lack any of material dispute, at least historically, as to such breaches and the reality that the nub of the case, in our view, is primarily about (1) the nature and degree of any subsequent improvements (or improvements that had been started) and/or (2) the material change in circumstances arising from any decision by the Appellant to stop carrying on relevant regulated activity from the Location.

75. That said, we are satisfied, on the balance of the probabilities, that all of the

breaches set out in the Schedule (save for the limited exceptions), as the time of the on-site inspection on or around 19 and 21 March 2024, have been established by the Respondent and/or by admissions from the Appellant. We should, therefore, summarise those breaches. Collectively and in the round, they were relatively serious. In summary, they included the following:

(a) The Appellant breached regulation 9 (relating to person-centred care). For example, there were failures relating to: using preferred communication methods; the provision of food/drink; adaptations to support sensory needs; positive behaviour support ("PBS") plans; the prevention/management of self-injurious behaviour; involving service users in assessments of their needs and preferences (e.g. in relation to tailored activity plans).

(b) The Appellant breached regulation 12 (relating to safe care and treatment). There were, for example, failures relating to reporting, documenting, assessing, investigating and/or mitigating risks to service users and/or incidents – including, but not limited to, risks relating to choking, fire, self-injurious behaviour, movement of service users, medication management.

(c) The Appellant breached regulation 13 (relating to safeguarding service users from abuse or improper treatment). For example, there were failures relating to the proper, timely, and/or least-restrictive use of DoLS.

(d) The Appellant breached regulation 17 (relating to good governance). For example, there were failures relating to: effective audits, quality assurance processes, and/or other systems, and their ability to adequately identify relevant risks and issues; sufficient action in relation to risks or concerns; satisfactory completion, monitoring and/or assessment of incident/accident reports (or the absence of such reports).

76. These were summarised, with evidence provided in support, within the Notice of Proposal and, in due course, by the Notice of Decision.

The Notice of Proposal

77. We do not need to consider whether the Notice of Proposal was proportionate at the time it was issued. We do not do so. Our focus is on the situation as at the time of the Hearing.

Subsequent developments

78. It is important, in this case, to consider subsequent developments. In our view, in summary, things changed. There were two broad elements of change: (1) the improvements that occurred and/or were in the course of being implemented; and (2) the decision to cease operating from the Location and the implementation of that decision. We take each in turn, beginning with the improvements.

Material improvements

79. There developed, we are satisfied, a very substantial focus from the most senior

leadership at the Group. That focus developed rapidly from or around 13 March 2024. By then, the decision of the Council to activate its provider of concern process, and any potential link between SU3's death and any choking incident, was becoming clearer to senior leadership. A structured and heavily-resourced intervention package was put in place, designed to address the most serious or immediate risks/issues rapidly, and to better manage any wider risk/issues more generally. Actions were initiated and tracked.

80. In summary, and adopting as before a relatively broad-brush and proportionate approach to such matters, in relation to the Regulations engaged:

(a) We are satisfied that there was significant and material improvement in relation to regulation 9. At least partially-effective steps were taken, for example, to: support staff to communicate better with service users; provide more person-centred care in relation to eating and drinking; produce or improve tools/plans/guidance with regard to, and deliver specialist training on, PBS principles/practice; involve service users more in assessments/ plans regarding individual needs/preferences (e.g. in relation to activities).

(b) We are satisfied that there was significant and material improvement in relation to regulation 12. At least partially-effective steps were taken, for example, to: assess and mitigate risks to health and safety (and review relevant risk assessments) for service users; make hospital passports available; improve/promote the management of incidents (e.g. including self-injurious behaviour, with an associated reduction in such incidents as staff awareness and confidence developed); improve the management of eating and drinking care needs/risks/plans, with support from external SaLT professionals, and any immediate risks relating to fire, in particular; enhance capabilities in relation to safe movement and positioning of service users; enhance the safe management of medication (following intervention from Ms Loizou, who also shared her knowledge/practice to upskill staff); improve staff handover sheets.

(c) We are satisfied that there was significant and material improvement in relation to regulation 13. At least partially-effective steps were taken, for example, to: review DoLS authorisations, to bring them up-to-date among other things; improve the wider system so DoLS authorisations would be completed as part of care plan reviews.

(d) We are satisfied that there was significant and material improvement in relation to regulation 17. At least partially-effective steps were taken, for example, to: take a more pragmatic and effective view in relation to the reliability of internal audits, and to carry out two additional audits; drive rapid change and improvement, in particular via the use of additional resource and an extensive improvement plan; improve incident/accident reporting, in line with polices, on the electronic reporting system (RADAR), with a greater focus on identification of relevant trends, and encouragement of prompt and fuller reporting (with active promotion of the whistleblowing policy); improve monitoring of staff training needs and delivery; enhance staff supervision and hold more regular/effective meetings; review staffing arrangements,

including agency provision; raise willingness and capability to investigate poor practice if and when identified; collaborate effectively, on important matters, with partners such as the Council; enhance oversight, more generally, from the senior executive leadership.

81. Significantly, experienced and, in our view on the evidence before us, competent senior staff, including but not limited to Ms Loizou and Ms Bridger, were on the ground delivering training and guidance to staff, directly or indirectly though their own practice and role modelling. In this and other ways, skills, confidence, and standards were increased, at least to some material extent, among other staff.

82. The best evidence supporting our view that there was some real and significant improvement includes the following:

    (a) The Respondent agrees that there was at least some material improvement in relevant areas. We take a different view to the Respondent on the degree or extent of such improvement – in other words, we think it went further than the Respondent accepts. That said, we acknowledge the (detailed) points set out by the Respondent, in the written statements in particular, which indicate that the evidence provided by the Appellant did not demonstrate that the improvements implemented by it had fully remedied all breaches.

    (b) The written and perhaps in particular the oral evidence from the Appellant's witnesses, provided, when viewed collectively, persuasive evidence, in our view, that the real level of improvement on the ground was greater than the Respondent has felt able to accept. That said, while there is some more contemporaneous documentary evidence from the Appellant (including updates to the improvement plan) to support our view, we agree with the Respondent insofar that the Appellant could have done a better job at gathering, packaging, and sending such documentary evidence, at the time, to the Respondent (and indeed to us within the context of these proceedings).

    (c) We are emboldened in our view by the fact that the Council visited, twice, and did so following the Respondent's two early assessment visits. We place significantly greater weight on the evidence relating to that, including the positive formal written report(s), and the Council's decision to end its provider of concern process. While we recognise that the Council and the Respondent have different aims, interests, standards, and processes etc, we think there was a greater degree of overlap, in this particular case, than the Respondent accepts. We place some significant weight on the evidence relating to the Council. It benefitted from actually going in to the Location during April 2024. It found evidence, on site, when it did. We do not accept that the Council, on the evidence, was simply focused on moving service users on or merely on commercial or contractual matters. It was focused on matters which were relevant to the breaches and the improvements that we find were made.

    (d) We are further emboldened in our view by the Group's benchmark audits conducted in April and early May 2024. There was a substantial

improvement, within just 20 days or so, from a 48% ("inadequate") score in April, to a 63% ("requires improvement") score in early May. There was, in addition, in our view, likely to have been some further improvement between that second visit and the effective closure of the Location on 20 May 2024, as indicated by the Appellant's oral evidence and the 15 May 2024 version of the improvement plan.

83. In addition, we think some other factors are relevant and, when combined, further support out view, including the following:

(a) The Respondent appears to us to have adopted the following broad view or approach: (i) material breaches were firmly established at a relatively early point in the chronology; (ii) the Appellant did not go on to demonstrate/ prove, by documentary evidence, that it became compliant in relation to those breaches; and (iii), as a result, the Decision has continued to be, and remains as at the date of the Hearing, according to the Respondent, proportionate.

(b) That type of approach, in our view, may be too simple an approach, at least in relation to this specific case. Further and in any event, it does not equate to the test we apply. We must take a careful and balanced approached, especially when considering proportionality. Full compliance with the Regulations is not, in our view, required. We ought not to set the bar too high. It would be sufficient, for the purposes of the Appeal, if the material improvement reached a level that, even if still below the Respondent's wider expectations, rendered the relevant regulatory action disproportionate. There is no need, for instance, for the provider to satisfy us that it has reached "good" overall, or even necessarily "requires improvement". But, in broad terms, we are satisfied that, on the balance of probabilities, the Appellant probably got to the latter by the middle of May 2024 or so at least.

(c) It was not, realistically, possible for the Appellant, in any event, to demonstrate full or perfect compliance or to fully complete the improvement plan, within the relevant timeframe. Staff appraisals and plans, for example, would, inevitably, take time. It would, similarly, take time to "demonstrate" a sustainable change in culture. Such things may also be inherently more difficult, in relative terms, to "prove" on paper alone.

(d) The Respondent, in our view, may have put the standard it expected the Appellant to meet (in order to not proceed with the proposed regulatory action) too high and/or placed too high an onus on the Appellant to prove such things on paper. For the purposes of the Hearing, the burden is more on the Respondent than the Appellant.

(e) The Respondent only visited the Location at the start of the most relevant part of the chronology. Things probably were relatively chaotic, at the Location, at that particular point. But in our judgment, things settled down, and improved over time. The Respondent did not get to see that directly.

Material change in circumstances – the decision to cease operating

84. We heard directly, in formal evidence under oath, from the Appellant's witnesses. We are readily satisfied that the Appellant made a genuine and firm decision – which it was, and which it remains, fully committed to – to effectively close the Location (or, more accurately, to cease the relevant regulated activity from it). It was not a mere "intention", let alone one that was flaky or unreliable, less still one that was lacking in honesty or integrity in some material way. Quite the opposite.

85. We are supported in this view by the oral evidence before us and by the documentary evidence at the time (most notably the letters dated 22 and 25 March 2024 to the local authorities and the Respondent). There is then strong further support by the subsequent conduct. The Appellant followed through by working with the local authorities to manage appropriately the transfers of all relevant service users. It made a formal application to the Respondent; we are satisfied that it did not chose to make that application earlier because (1) it did not and could not know the date that would apply to it (as it was unclear until later when the last service user would leave) and/or (2) to put such a timeframe on it would put unfair or otherwise undesirable pressure on people, such as the local authorities or others, to move people overly-rapidly or within a set period.

86. There is no or no sufficient upside for the Appellant, in all the circumstances, to seek to renege on the decision. Counsel for the Appellant, on instructions, went as far as to indicate a clear willingness to give a formal undertaking to the court. Further, even if the Appellant had some interest in reversing its decision, it would take a substantial amount of effort, time and/or expenditure to get things back in place – it would, for example, need to try to: find and place new service users (probably working again with the local authorities, as commissioners, to do so); recruit and on-board appropriate managers and senior staff; recruit and on-board a wider pool of capable staff; engage appropriately with the Respondent and others. The prospect of this happening, in our view, is remote at best.

87. We are similarly satisfied of the following in relation to this decision and the implementation of it:

    (a) It was a decision made by the most senior people at the Group, including the CEO, and including Ms Paterson and/or Mr Svensson, on or around 19 March 2024.

    (b) It was made in large part because of the reasons relied on by the Appellant in these proceedings: it was simply facing too many substantial operational challenges, at that particular site at and that particular time, to sustain the service efficiently. It was, in our judgment, mainly a commercial decision. The Appellant may, as part of its thinking, have had in mind the potential for some reputational damage arising from potential regulatory action; but that was not in our judgment, the effective or operative reason. It was not simply seeking to "evade" regulatory action or intervention. It was seeking, if imperfectly, to work with its regulator and other partners. It could, in our view, have maintained the improvements but to do so would have required a disproportionate ongoing level of focus and resource from the Group.

There were too many problems relating to vacancies/absences, and too many challenges regarding recruiting/retaining staff of sufficient quality at that time and place.

(c) We are satisfied that, in practice, the Appellant managed the transfer of service users in a sensible, compassionate, and effective manner, working collaboratively with partners, with relatively good outcomes for the service users. We take the view that, in a difficult set of circumstances, it was a reasonable decision and one which, in fact, had regard to the interests of the services users. There must, in our view, be circumstances in which a voluntary closure (or similar) of a location, even in the course of a regulatory process, is a reasonable option. While our decision must not be taken to provide any encouragement to less ethical providers to seek to close a site (or similar) in order to avoid or evade regulatory action, we would, similarly, not wish to close off the option of closing a site (in an appropriate manner) where it otherwise would make sense to do so.

Making the decision at this point in time (or, more accurately, the date of the Hearing)

88. We consider it useful to make use of, or at least have reference to, the Enforcement Policy and the Decision Tree as a guide to decision-making. That is what the Respondent would do and we are meant to be stepping into its shoes.

89. The Enforcement policy highlights that the Respondent "accepts that there will be occasions when more facts emerge later in the process, or disputes of fact are resolved, and therefore enforcement action is no longer required" and that "if we believe such a stage has been reached, we will cease enforcement". It states that the Decision Tree guidance should be read. It states that the Respondent "may work with a provider without using enforcement powers to improve standards where the quality or safety of a service is below those required, but we assess the risk of harm is not immediate and we consider the provider should be able to improve standards on its own". It states that "the starting point" for considering the use of all enforcement powers is to assess the harm, or the risk of harm, to people using a service, adding: "We will only take action that we judge to be proportionate to the circumstances of the individual case. If we judge that the provider can improve the service on its own – and where the risk to people who use services is not immediate – we aim to work with them to improve standards rather than taking enforcement action."

90. The Decision Tree guidance has two highly relevant sections, each with sub-sections, which it refers to as Stage 3A and Stage 3B. Before moving towards Stage 3, however, the Decision Tree guidance states that the Respondent will "bear in mind the importance of working co-operatively with registered persons".

91. Stage 3A is about assessing the seriousness of the material breach. Stage 3A(1) is about assessing the "potential impact that would result if the breach of regulations identified was repeated". The focus is on re-occurrence, to assess whether action should be taken to protect people from future harm. The decision-maker is invited to categorise the potential impact as "major", "moderate", or "minor", with some brief guidance regarding the same. The final submission from

the Respondent, modified in oral submissions from that initially suggested in written closing submissions, was that the potential impact, based on the evidence of the Respondent's witnesses, should now be considered "moderate". In our judgment, the proper categorisation of potential impact, as at the date of the Hearing, is at least "moderate" but could perhaps be "major". Repeated breaches of the types recorded in the Schedule would result, as required by the Decision Tree guidance, in a risk of harm including temporary disability and/or reversible adverse health conditions and/or significant infringement on someone's rights of welfare (of more than one week but less than one month) and/or moderate reduction in quality of life. We have in mind, for example, repeated breaches in relation to DoLS or in relation to inadequate management of choking risks or self-injurious behaviour risk. Such matters could cross the threshold into "major", on the basis that they – or at least some of them taking at their highest – would result, for example, in a risk of harm of a significant infringement on someone's rights of welfare (of *more* than one month's duration) and/or a *major* reduction in quality of life.

92. Stage 3A(2) is then about assessing the likelihood that the facts giving rise to the breach will happen again. This should be based on a provider's control measures or processes in place to manage the risks identified, including changes in practice. The decision-maker is invited to categorise likelihood as "probable", "possible", or "remote". In our judgment, at the time of the Hearing, the proper categorisation of likelihood is either "remote" or at most "possible". If one disregards entirely (despite that appearing to us to be illogical and divorced from reality) the fact that, as we have found it, the relevant service will almost certainly no longer be provided by the Appellant at the Location in the future, and focuses purely on the risk (hypothetical and artificial though that may well be) of some recurrence if the service was to be provided following the improvements made (or which would be made or continued) by the Appellant, one could put it in the "possible" category on the basis that: "some control measures have been put in place, but these are not completely effective". Then again, one could chose the "remote" category on the basis that: "it is unlikely … as control measures have been put in place to manage the risk identified, although they may be newly implemented and/or not embedded". If, on the other hand, one takes into account the fact that the relevant service was discontinued and will very likely remain so, then that points firmly to the "remote" category, especially if one also were to take into account the improvements that we find were made before the service was discontinued. We do not think that the likelihood could properly be said, on any reasonable view, to "probable". With respect, we do not consider this part of the Decision Tree guidance to be drafted as helpfully as it could be. But on balance, we think that the likelihood, properly viewed objectively, is best categorised as "remote".

93. Using the simple table or grid provided in the guidance at Stage 3A(3), that then means that the overall seriousness would either be (1) "low" (i.e. if the potential impact was "moderate") or (2) "medium" (i.e. if the potential impact was "major").

94. Applying the guidance at Stage 3A(4), that would then mean that the "initial recommendation" would be (1) conditions or a warning notice, if the seriousness was "medium" or (2) a mere action plan request, if the seriousness was "low".

We note, here, that the initial recommendation, if seriousness is "high", includes "more significant" conditions. We take the view that the condition applied in this case – the removal of the Location – falls into the "more significant" category of condition. As such, that level of intervention would appear to be disproportionate, if one were to simply follow the Decision Tree guidance, unless the operation of Stage 3B got the decision-maker into that area, so we turn to that next. We also note that if the seriousness is only "low", the recommended option of a request for an action plan is stated as being to take "regulatory action" rather than "civil enforcement action".

95. Stage 3B is said to be about "identifying multiple and/or persistent breaches". In essence, following the initial recommendation stage, the decision-maker is then meant to apply the test in Stage 3B to consider whether a more or less serious level of enforcement action is justified. The decision-maker is invited to make four mini-decisions and then apply the answers.

96. First, at Stage 3B(1), the decision-maker is invited to decide whether there has been a failure to assess or act on past risks. In our view this is not necessarily an easy question to answer in this case. We have sought to take a pragmatic approach and take into account the reality of the situation. That reality includes the fact that the Location and/or the three locations are now controlled by the Group. We therefore have regard to that. On balance, we do not think, objectively viewed in the round, there is any extensive "history" of "failing to adequately assess risks to people using the services" or "failing to act on identified risks" to such people ("including a failure to act on previous CQC assessment reports, requirements" etc). It could be said that there was a limited and recent failure to do so, at the Location or perhaps the other two sites following the merger/ acquisition by the Group. But, overall, looking more broadly at the "history", over a fairer period of time, and giving some weight to the good record across the Group, and giving some weight to the evidence of recent responsiveness (in terms of the improvement actions) and decisiveness (in terms of the decision to stop carrying on the regulated activity from the Location), there is in our view no such "history".

97. Second, at Stage 3B(2), the decision-maker is invited to decide whether there are "multiple breaches". This is more straightforward. This is a factor which would count against the Appellant and towards more serious intervention.

98. Third, at Stage 3B(3), the decision-maker is invited to decide whether the "provider's track record" shows "repeated breaches". Again, here, we think that, in reality, one has to consider the track record not just of the Appellant but also of the Group. The latter, on the evidence before us, which is not challenged, appears to have a strong track record. The former appears to have a reasonable track record, until the last 12-18 months, when things became more problematic. Overall, we think that this is probably a factor in the Appellant's favour.

99. Fourth, at Stage 3B(4), the decision-maker is invited to decide whether there is "adequate leadership and governance". There appears, quite clearly, to be a divergence in views between us and the Respondent in relation to this particular matter. We, however, have had the benefit of hearing directly from such

leadership and about such governance. Overall, we are satisfied, having proper regard to the leadership and resources of the Group, that this is a factor quite strongly in favour of the Appellant. We consider it to be an important factor.

100. At Stage 3B(5), the decision-maker is then invited, it seems, to step back to consider whether or not to change the civil enforcement action due to answers in the Stage 3B analysis. Overall, and on balance: we do not think that there is a sound basis to escalate civil enforcement action to a more serious level; on the contrary, we take the view that, cumulatively, the assessment at Stage 3B points towards a taking less serious regulatory intervention rather than civil enforcement action.

101. We note that there is also a Stage 4 in the Decision Tree guidance. We do not however think that anything set out there assists us materially or changes the analysis any material way.

102. As a consequence, and irrespective as to whether it may have been at some earlier point in the chronology, we do not think that the Decision is objectively justified as proportionate as at the date of the Hearing. We think that in principle an action plan may have been sufficient to achieve the Respondent's legitimate aims. But that, in our view, by the date of the Hearing, cannot be considered to be both appropriate and proportionate, given the salient fact that there is no relevant regulated activity being carried on at the Location. In short: in all the circumstances, we are not satisfied that the Decision, objectively viewed at the time of the Hearing, is proportionate to the relevant risk(s). That level of regulatory intervention is not reasonably necessary, as at the time of the Hearing, in order to achieve the legitimate aims of the Respondents.

103. We should highlight that in coming to our view, we have given consideration to, and had due regard to, the wider matters that, for instance under section 4 of the Act, the Respondent must have regard to in performing its functions. We agree with the parties that the most obviously relevant and important matter, in cases such as this where regulatory action is being considered, is section 4(1)(e); and, on balance, as indicated, we think that points away from upholding the Decision. The Respondent did not construct a persuasive argument that any of the alternative provisions within section 4 are sufficient, whether taken on their own or together, to justify the Decision. We do not, in this particular case, think that they do. We do not, take one example, think that the Decision is justified as proportionate in order to allow the public to be aware of regulatory action that the Respondent has sought to take against the Appellant, especially in circumstances where we have decided that that action is now disproportionate and in circumstances where (1) there will in any event still be a record of the "inadequate" rating in relation to the Location, (2) these proceedings form a further element of a public record, and (3) there is no longer any relevant regulated activity being carried on at the Location.

104. Finally, we also wish to clarify that we are not, in terms of our overall decision, seeking to criticise the Respondent for issuing the Notice of Proposal or the Notice of Decision, or for electing to defend the latter in these proceedings. We understand why it took each of those decisions. Ultimately, we have simply

reached a different view, based on evidence that was not available to it, at a subsequent point in time. Notwithstanding our decision and the outcome of the Appeal, the Respondent has, in our view, sought to carry out its important statutory role in a proper way.

OUTCOME

105. The Appeal succeeds. We direct that the Decision shall cease to have effect, pursuant to section 32(3) of the Act.

Judge SJW Lewis

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

Date Issued:19 May 2025