

Care Standards

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

BEFORE

Miss Maureen Roberts, Tribunal Judge
Mr Brian Cairns, Specialist Member
Mrs Sallie Prewett, Specialist Member

BETWEEN

Mr J A Corney and Mrs J P Webb

Appellant

v

Care Quality Commission

Respondent

[2015] 2547.EA

DECISION

Heard on 27, 28 and 29 April 2016 at the SSCS Tribunal Hearing Centre Blackbrook Taunton.

Representation: Mr Corney attended and represented the Appellants. He gave evidence. He was assisted by Ms Ashleigh Richardson (Mrs Webb's grand daughter). Mrs Webb did not attend the hearing.

The Respondent was represented by Mr Sapiecha of Counsel, instructed by Ms Sproson Solicitor from the Legal Department CQC.

The tribunal heard evidence from Ms S Scott Lead Inspector, Ms Y Ellaway Inspector, Mr R Gleave Inspection Manager, Ms N Nendick Head of Inspection South West of England and Ms Sanderson Head of Inspection North of England.

The appeal and chronology

1. On 28 October 2015 the respondent served on the appellants notice of its decision to cancel the appellants registration as a service provider for a regulated activity. The appellants appeal against this decision.
2. Prior to the service of the October notice the respondents had conducted a number of inspections. Following a comprehensive inspection on 9 and 14 January 2015 a warning notice was served and written representations received from the appellants.
3. Following a focused inspection on 23 and 29 April 2015 and a management review meeting, a notice dated the 12 August 2015 was served by the

respondent which was a notice of proposal to cancel the appellant's registration as a service provider in respect of a regulated activity.

4. The reasons set out in the August notice were as follows 'we have inspected your service on four occasions since January 2013 and have found that there have been breaches in regulations on all occasions. In particular there have been continued breaches relating to your ability to appropriately assess people's needs, to ensure that their care and treatment is provided in a safe way and that it is appropriate, meets their needs and reflects their preferences. Enforcement action has been taken and this has not resulted in the regulations being met. Our findings do not provide us with any confidence in your abilities to meet the requirements of a number of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.'
5. Following the August notice written representations were received from the appellants opposing the cancellation. These and the respondents' evidence were reviewed by an independent head of inspection who endorsed the proposed cancellation.
6. There was a further comprehensive inspection on 27 and 29 October 2015 and an inspection on 14 April 2016.
7. The appellants appealed on 24 November 2015.
8. The breaches are disputed. The appellants assert that they comply fully with the regulations and in fact that they exceed them. They contend that they have run their service successfully for the past 21 years and that they have only ever had one substantiated safeguarding issue made against them.

The background

9. The appellants purchased the property, Thistlegate House, a large Arts and Crafts property in 1994. They purchased the property as a going concern as a residential home. They state that they had no previous experience in residential care but were very committed to providing a residential care home with high standards and a good quality of care.
10. The appellants were registered as the service providers on 1 October 2010, by the respondents. This was pursuant to the transitional provisions for existing providers.
11. The regulated activity at the home is, 'accommodation for persons who require nursing or personal care' and the maximum number of service users is limited to 18. The accommodation was restricted to being a care home without nursing.
12. The respondents rely on the findings of successive inspections and incidents dating from 8 January 2013.
13. On 8 January 2013 there was an unannounced inspection by the respondents. At that inspection it was recorded that training that required updating, had not been identified and the provider did not complete appropriate supervision or appraisal with staff. An action plan was required to be submitted by 22 February 2013. In June 2013 respondents received an action plan from the appellants.

14. In December 2013 and February 2014 there were a number of safeguarding meetings by Dorset County Council. The investigations substantiated two complaints regarding to inadequate pressure sore treatment for two of the residents at Thistlegate House. In November 2013 Dorset County Council ceased to commission care at the home due to safeguarding concerns.
15. On 13 January 2014 there was an unannounced inspection of the home. The inspectors concluded that the provider was failing in two regards. Firstly a breach of regulation 9 (2010), in that people's individual needs were not assessed and some assessments had not been completed accurately. Secondly, care was not always planned to meet people's needs. The home's response was not always timely when a potential risk was apparent. Staffing knowledge was inconsistent.
16. The report also concluded that there was a breach of regulation 20 in that some people's care records did not contain accurate information and some care records contained inconsistent information.
17. An action plan was required by 26 February 2014 and was received in April 2014.
18. On 9 January 2015 and 14 January 2015 there was an unannounced comprehensive inspection. The inspectors rated the provider as inadequate as an overall rating. All sub ratings were 'inadequate' or 'requires improvement'. They concluded that the breaches of regulation 9 continued.
19. The regulations were in the process of transferring to the new 2014 regulations. For clarity the tribunal are listing the old and new regulations alongside each other.

(2010)	(2014)
9	9 & 12 Care and welfare of Service users/Person centred care
10	17 Assessing quality of service/Good governance
11	13 Safeguarding from abuse
13	12 Management of medicines/ safe care & treatment
17	10 Dignity and respect
18	11 Consent to care and treatment
21	19 Requirements relating to workers
23	18 Supporting workers

These regulations have been of concern to the respondents throughout the inspections from January 2015 onwards.
20. As a consequence of these findings a warning notice was issued on 19 March 2015 with a compliance date of 9 April 2015. The respondent considered the seriousness of their concerns, in combination with the persistent and multiple breaches, had led to the decision to issue a warning notice.
21. The appellants filed written representations disputing the correctness of the findings of the written warning. These were considered by the respondent. The respondent concluded that the breaches continued and that the appellants remained non-compliant.
22. There was an unannounced focused inspection on the 23 and 29 April 2015 concentrating on the issues that had arisen in the previous inspection namely safe, effective and responsive service.

23. On 12 August 2015 the notice of proposal to cancel registration was issued. The appellants made written representations. These were reviewed by the Head of Inspection in the North of England who had had no contact or prior involvement with the case. She upheld the proposal taking into account, the current state of the service being provided, the level of evidence provided by the respondent, the representations of the appellant and a review of the respondent's findings including the last report. The decision was therefore made to cancel the appellants' registration.
24. As noted the home is registered for 18 residents. Over recent years the numbers have declined. In April 2015 there were seven residents. Currently there are no residents in the home. Mrs Webb's aunt is the last remaining resident, and she is currently in hospital.

The Law

25. The respondent is a statutory organisation set up under the Health and Social Care Act 2008 (the Act). It has the statutory responsibility to inspect regulated activities. The regulated activity in this case is providing 'accommodation for persons who require nursing or personal care'.
26. The Act, in section 7C (1) gives the respondent discretionary power to cancel the appellants registration in respect of a regulated activity at any time when the regulated activity is being or has been at any time carried on otherwise than in accordance with the relevant requirements. It is not in dispute that the appellants are carrying on a regulated activity.
27. Section 17 (4) states that, in this section, relevant requirements means any requirements or conditions imposed by or under this chapter and the requirements of any other enactment which appears to the Commission to be relevant. The regulations under the 2010 and 2014 regulations are relevant requirements.
28. The tribunal has the power to confirm the decision of the respondent, direct the decision of the respondent to have no effect and to direct the imposition of any such discretionary condition as it thinks fit.
29. Tribunal considers the appeal on the basis of the available evidence at the time of the hearing.

The issues

30. Panel noted the history regarding Thistlegate House and the relationship of the appellants with the respondent and Dorset County Council (DCC). The appellants described the relationship as 'colourful' and the panel would accept that it has been difficult.
31. The current registration certificate is dated 1 October 2010 and we had copies of the inspections from January 2013 onwards. We note that both sides said Thistlegate House had always had judgements of poor, inadequate or requires improvement since 1998 except on one occasion when inadequate judgement was changed to good. The appellants said that this was because the inspecting authority was threatened with legal action.

32. There was a dispute about the number of breaches, the period the breaches persisted and the seriousness of the breaches.
33. The inspection reports cover a wide survey of both patient care and safety together with issues regarding the physical state and cleanliness of the property.
34. The respondents stated that they were relying on the inspections carried out since January 2013 as well as the attitude of the appellants towards the findings and their inability or unwillingness to improve or change. They also noted information that they had received from other organisations such as Dorset County Council.
35. The respondents said that there have been persistent breaches that have occurred over a long period of time and that they are significant and serious. Significantly they said the appellants have not responded to the breaches and not shown any willingness to improve. They did not consider there was any prospect of an immediate improvement by the appellants.
36. The respondents said that the regulated activity conducted at Thistlegate House was not being carried out in accordance with the relevant requirements in force at the material time.
37. Mr Corney set out very clearly the philosophy and ethos of himself and his partner. He said that they had come into the residential home business with little previous experience but with clear intentions of providing a very caring environment for their residents. He spoke of following a European model where elderly people live at home with their relatives. He said that he and Mrs Webb live in the house with the residents and that it was their home.
38. Mr Corney was of the view that respondent inspectors had acted without integrity. In his written statement he described the professionals involved with the home as 'despicable manipulators' and that they 'should be barred from working in the industry'. He challenged the findings of the inspection reports and disputed that they were factually correct. He questioned the professional opinions of the inspectors.
39. He repeatedly said that the business was run in accordance with his own philosophy to a very high standard and that both service users and their relatives were content with service provided.

Evidence

40. The tribunal had the benefit of reading the bundle which included all the inspection reports since 2013, together with the factual accuracy comments logs submitted by the appellants, handwritten notes of the inspectors findings at the time of the inspections, correspondence between the parties, training certificates, minutes of management review meetings, minutes of DCC safeguarding meetings, and copies of care plans and records for the residents. The panel also had witness statements from the Respondent's witnesses and statements from Mr Corney.
41. The panel heard from the witnesses present and Mr Corney. We had a statement from Mr Alan Chambers of Dorset County Council. He did not

attend to give oral evidence as Mr Corney had indicated that he did not need him as a live witness.

42. We briefly summarise the evidence given by each witness, both in their written statements, and orally to the tribunal.
43. Ms Scott is a Lead Inspector with the respondent. She said that an inspection had been carried out on 8 January 2013. She did not conduct the inspection.
44. On this inspection compliance action was requested from the appellants because training that required updating had not been identified and no record of staff appraisal or supervision was recorded. The appellants sent an action plan to the respondents on 15 June 2013.
45. Subsequently she said that as the result of a safeguarding investigation, which found that a resident had not received the appropriate care, equipment and monitoring which she required, the respondent had initiated the inspection of Thistlegate House on the 13 January 2014.
46. On this inspection there were breaches of regulations 9 and 20. It was found that assessments had not been completed accurately and that some people's care records did not contain accurate information. The appellant sent an action plan to the respondents on 3 April 2014.
47. Ms Scott first became involved with the appellants when she conducted an inspection on the 9 and 14 January 2015. She found that the actions that the appellant said they would take in their action plans had not been carried out and there were further breaches.
48. The inspectors found a breach of regulation 9 of the 2008 regulations in that 'the registered person had not taken steps to ensure people were protected from the risks of unsafe or inappropriate care through assessment of needs and subsequent planning and delivering care'. A warning notice was issued regarding this breach.
49. The report found that the appellants were in breach of Regulations 10 to 13, and 17 to 19 of the 2014 regulations. These included people not being protected from avoidable harm because risk assessments were not updated. People did not receive their medicines safely. Safeguarding issues raised by Dorset County Council had not been investigated by the appellants. People's consent to care was not being covered under the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) had not been applied for. No resident had had a DOLS assessment. Staff were not supported to develop their skills. People in the home were sometimes treated in ways that were not respectful and the end of life wishes had not been discussed or recorded.
50. Further the appellants had not identified any areas of development of the service and the issues raised by the inspectors had not been identified by the appellants. The inspectors made recommendations about improvements in infection control and the provision of activities for people in the home.
51. The inspectors also recorded that the residents said they were happy in the home and that their relatives said they were content with the service that they were receiving. Ms Scott outlined the receipt of the appellants factual accuracy comments log and the publication of the January report.

52. In April 2015 Ms Scott was the lead inspector for a focused inspection to follow up on action that was required from the appellants as outlined in the warning notice issued in March 2015 after the January inspection.
53. The summary of findings at the end of this inspection, were much the same as those found in January. The report noted that in April 2015 there were five people some of whom had complex care needs, associated with dementia and restricted mobility, living in the home. The overall rating for the service was inadequate. Referrals had been made for DOLS assessments for all the residents.
54. Again the inspector concluded that people's needs had not been assessed appropriately. There were some residents experiencing continence care that was not appropriately assessed. People were at risk of avoidable harm. People did not have access to meaningful activity. Professional guidance was not sought as an integral part of assessment and care planning. Some residents told inspectors that they were happy with the care that they were receiving.
55. On the 27 and 29 October 2015 Ms Scott was the lead inspector in a inspection visit to Thistlegate House. She attended with Ms Ellaway who also gave evidence to the tribunal. The inspection report concluded that the overall rating for the service was inadequate and that the service was therefore in special measures. The summary of findings in the report repeats the failings as had been recorded in January and April. It noted that peoples end of life wishes had been recorded although it was not clear how these decisions had been made.
56. It was recorded that staff did not know where to report abuse and that the information available to them was out of date. Further staff did not have a shared understanding of the evacuation procedure and fire exits were blocked.
57. The report concluded that the service was not well led because the guidance and requirements of other agencies had not been followed. The action plans from previous inspections had not been carried out. Environmental health requirements not been acted upon. This put people at continued unnecessary risk. It also noted that the registered manager did not engage professionally with the inspection process.
58. Ms Scott was asked about a number of findings that she had made. In October 2015 she had recorded that there was a trip hazard, which she subsequently amended to say environmental hazard in that there was a sloping floor outside one of the residents' doors.
59. The appellants argued that this was part of the structure of the building and had been there for as long as the house had stood. Ms Scott acknowledged that this was probably true but that the appellants needed to be aware of the possible risk for residents.
60. She had also noted that there were miscellaneous items on the floor and that three doors, which she said were signed as fire doors, were blocked or had draught excluders in front of them. This issue was noted on the written feedback to Mrs Webb at the end of the inspection.

61. Ms Scott submitted there were concerns about the care plans. There were no outcomes noted to measure if care was adequate. Care plans were kept in an ineffective system and changes in people's needs were not being recorded and picked up by staff. She gave an example of one person's continence needs changing and another person who needed some meaningful activities in the day, which were not recorded.
62. Ms Scott said that she had discussed the breaches with Mrs Webb at the end of each inspection and there was a handwritten note recording what she had discussed. She said there were no effective systems to ensure provision and improvement of quality assurance in the home.
63. She noted that throughout the inspections no supervision or appraisal of the staff was recorded though she accepted that the majority of the staff said that they felt supported. She said that it was a regulatory requirement that proprietors kept records to monitor people and objectively review residents' care, to ensure that the appropriate and current care was in place.
64. Records should also ensure that the Mental Capacity Act is being applied correctly. She said that she was using her professional judgement in considering the provision in the home and weighing up what people should be able to expect.
65. She said that the care plans were not accurate or complete. The information in a care plan should be sufficient so that a new member of staff would immediately know the situation. She also noted that medication records were not accurate and that there were tablets missing.
66. Ms Ellaway is an inspector with the respondents and attended the October 2015 inspection. She confirmed the findings of that report but did not take any part in the decision-making process or the writing of the reports. She had checked the medication in the home and found for example, in respect of one medication that there were nine tablets unaccounted for, though subsequently, three further tablets were found.
67. She noted that the staff and Mrs Webb did not appear to understand the implications of the Mental Capacity Act and the DOLs provisions.
68. Finally she had recorded that Mr Corney had been very angry and had shouted at the inspectors during and at the end of the inspection.
69. Mr Gleave is the line manager for Ms Scott and therefore reviewed the inspections of January and April 2015. He noted that there had been a lot of different issues which had caused concern to the inspectors and which had resulted in the overall judgement of inadequate for the home. Following the January 2015 inspection a warning notice was issued and then a full focused inspection (in April) was undertaken to see what had been done in response to the warning notice.
70. Mr Gleave carried out a further inspection on 14 April 2016 to update the situation for the tribunal. He visited and said that the visit lasted 17 minutes. He had planned to look at all areas to be inspected. However he was told that, neither the appellants nor the staff would engage with him. He was allowed entry in to the building and spent a few minutes with the two residents

who were in the house. He said he could not tell if any improvements had taken place. He was not permitted to look at any paperwork or to speak to the staff. He said that Mr Corney was quite hostile and angry.

71. This most recent report, in draft, concluded that the provision was still inadequate and noted in particular that two notifiable incidents, one resident sustaining a fractured hip and another resident having had a fresh DOLs assessment from DCC, had not been notified to the respondents.
72. Mr Gleave explained that, after every inspection, the appellants have the opportunity to correct factual inaccuracies and a further opportunity to make representations in respect of the overall rating.
73. Mr Gleave said he had been involved in the Management Review Record on 3 February 2015 when the meeting had decided to issue a warning notice. He had attended the Management Review Record on 18 May 2015, when a decision had been made to send the notice of proposal to cancel.
74. The respondents have a decision tree which they work through, in deciding what level of enforcement to apply. Mr Gleave said that other options short of cancellation were considered but in the light of the history and the lack of response to requests for improvement, the decision was made that recommendation would be made to the Head of Inspection for the South West to cancel registration.
75. He also said that there were a number of publications e.g. a Provider Handbook that were available to help home providers with guidance about how to comply with the regulations.
76. Ms Nendick is the Head of Inspection for the South West and is responsible for the decision regarding the issue of a cancellation notice and other enforcement decisions. Mr Corney had objected to her giving evidence to the panel on the grounds that she was not objective in her views. We considered this submission. We decided that Ms Nendick had acted in her professional capacity through out the proceedings and that it was appropriate to hear her evidence.
77. She said that there had been serious concerns about the service and quality of care for some time. She had considered the level of compliance and response over the years. She noted that the ratings have been inadequate for some time and that the residents were receiving an inadequate level of care. She had decided that alternative enforcement procedures would not achieve any lasting or fundamental change in the service. She said that the service been failing for a number of years and she considered, on the basis of the reports, that the decision to cancel was justified.
78. Ms Sanderson is the Head of Inspection for the North of England and she carried out an independent review of the decision-making by the respondent in the south west in respect to Thistlegate House. She confirmed the documents that had been sent to her which included the inspection reports, response to those reports and details of the residents.
79. Ms Sanderson said that she had been concerned, that improvements had not been carried out and that the home still had failings and shortcomings. The

appellants' representations did not address these difficulties. She said she had taken some 30 hours to review the decision.

80. The tribunal had the statement from Mr Alan Chambers of Dorset County Council together with minutes of safeguarding meetings 6.12.2013, 7.2.2014 and 14.4.2014 undertaken by the council the contents of which were known to Mr Corney who had been present at the meetings.
81. The safeguarding meetings had been called following concerns being raised about extensive pressure sores for one resident, who was subsequently admitted to hospital for treatment of the pressure sores. The allegation that significant harm has occurred to this person due to neglect was substantiated and it was noted that professionals should have been contacted approximately one month earlier than they had been.
82. Two other women residents were found to have pressure sores. Safeguarding meetings had concluded, in one case, that an allegation of a delay in contacting the district nurses was substantiated. However it was felt that this was due to poor practice rather than neglect.
83. The panel heard from Mr Corney and had extensive statements and documentation from him. He confirmed that he and Mrs Webb had purchased the property Thistlegate House as a going concern as a residential home in 1994. He also confirmed that currently there were no residents in the home.
84. As noted above, Mr Corney described the philosophy behind the home as being on the European style. He said that he and Mrs Webb lived in the house as their own home. They did not have separate or private quarters and therefore, he said, they were available and on-call 24-hours a day every day of the week. He said that this ensured that residents had a safe level of care.
85. He said that he and Mrs Webb had a passion for what they do and they felt that their methods and ways of caring for people and keeping records, whilst they might be peculiar to them, were ideally suited to their system of care.
86. He complained that Dorset County Council had put a secret block on placing residents in their home back in 2007 and an official block in 2013.
87. Mr Corney produced a letter from the Dorset Fire service confirming that the fire regulations had been complied with in the house. In particular Mr Corney said that the fire doors that Ms Scott had said had been locked or obstructed were not in fact fire doors and did not have fire notices on them.
88. On being questioned Mr Corney said that he considered there was an underlying agenda to close his business and that this had been going on since 2000. He was suspicious that deliberately false reports were being made. He repeatedly said that he did not accept the evidence of the inspectors and referred to the respondent's evidence as not being 'factually correct'.
89. As noted, Mr Corney referred to the members of staff of the respondent as being 'despicable manipulators'. He felt that the breaches mentioned had not been substantiated and he did not think there were any safeguarding issues.
90. With respect to the care plans in the home, the panel had large quantities of copies of care plans for residents together with daily notes. Mr Corney said

that the records were in 'many many places'. He said one set of records with general instructions about the person would be in his or her room. Dietary intake for breakfast lunch and supper would be in three separate books, night observations, day observations were in separate books as were visits by professionals such as district nurses or doctors.

91. Mr Corney was questioned about the care notes, and for example it was suggested to him that keeping all the residents notes together like hospital notes would be a more effective system. He disagreed with this suggestion. He said that their system was the way that the home had always kept the care plans and they wanted to keep it that way . He spoke about paperwork being manipulated. He also complained that inspectors spent far too much time looking at the paperwork and not enough time speaking to the residents and staff.
92. Mr Corney was asked about any external professional support that he had sought or whether he belonged to an association of homeowners. He said he had gone to one meeting but found that he did not agree with the way that they were running their homes and he had not looked for a wider peer group. He said that the home had a care magazine delivered, which was how they kept up-to-date.
93. Mr Corney said that he felt the respondents have never understood his home and the unique philosophy that they have regarding looking after older people in a home with them.
94. Mr Corney agreed that there had been a massive change in clients needs since 1994. Initially residents would be active and reasonably well. However there has been a huge change in that considerable extra care is being given to residents and residents are more frail and vulnerable.
95. Mr Corney was asked about supervision, appraisal and training of staff. We were shown a number of training certificates. This showed that one time the first aid training for Mr Corney and Mrs Webb was out of date. He said that informal training is given every day for staff. He also spoke about care plans being reviewed four times a day.
96. The issues arising at the safeguarding meetings by Dorset County Council were put to Mr Corney. He repeated that there had only been one substantive to safeguarding issue found against him. In that case, the woman concerned, he said, had been nursed by a relatively new member of staff and she had not brought it to his or Mrs Webb's attention that the woman concerned was beginning to have extensive pressure sores.
97. This evidence was in conflict with Mr Corney's repeated assertion that the four times a day staff discussions about residents ensured that all staff were always aware of all issues and changes regarding residents needs, whether or not these were recorded/updated in writing.
98. He agreed that he had said at the meeting that he would investigate what had happened. However he said he had not been able to do this because the member of staff went off sick and had never returned to work.
99. Mr Corney said on the issue of safety that there had not been a single incident of a client receiving the wrong medication. He said that the home

used the Boots dosette system and had monitoring reports from Boots to confirm the records. In respect of the patient with the missing tablets Mr Corney produced a medicine chart, which he said showed that the recording of medication administration was 100% accurate.

100. With respect to the recent incidents, which should have been notified to the respondents he said he had not had an opportunity to investigate why they had not been reported and considered that normally Mrs Webb would do this.
101. Mr Corney said that neither he nor Mrs Webb ever had protracted times away from the home and therefore they were invariably around to help with the running of the house and the care of the clients. He explained that he, and the staff understood how the recording system worked in the house. Since 1994 the house has had more and more records and he had every faith in his chosen system.
102. In respect to action plans not being put into practice he said that he realised that the respondents had asked for some changes to their systems however he did not want to change the systems and whilst they might start to follow an action plan they would then lapse or slip back.
103. Mr Corney complained about the ratings that had been given to the home, which he clearly thought were unfair said that they had only ever had poor inadequate or adequate and only one rating of good in 2010 when he said he had threatened the respondents with legal action.
104. Finally Mr Corney had made a number of formal complaints to the respondent alleging that reports and findings were libellous. He had wanted these to be taken into account by the reviewing officers and the tribunal. Whilst we noted the contents of these they are a separate issue, which will be dealt with after the tribunal hearing.

Conclusions and Decision

105. We carefully considered the written evidence submitted to the Tribunal in advance and the evidence given to us at the Hearing. We also took account of the legal provisions under the Health and Social Care Act 2008, the Regulations and relevant Case Law.
106. We accept the respondents' submission that that they have a defined statutory function and role and that they are required to carry out the function of independent regulation of health and social care. If a person is running a residential home then they must be inspected and must comply with the regulations.
107. This conclusion in itself means that the appellant providers must comply with the regulations particularly in respect of systems being put in place to prevent risk and to record the resident's progress and plans for the residents. (Regulations 10/17 and 9/9 and 12)
108. The appellants spoke about suffering at the hands of inspectors and of inspectors having a dishonest and deliberate agenda to cause them difficulties and ultimately close them down.

109. Mr Corney felt that the respondents have set out to cancel his registration and destroy his business. He said that they constantly refer to inadequate systems but he considered that there was not a shred of physical tangible evidence. He clearly believes that his administrative system is suitable. He went through the new regulations and said that he was not in breach of any of them.
110. On the issue of the fire doors being blocked as noted in the October 2015 inspection the panel concludes that the inspector saw doors which she considered were fire exits and that there was some kind of marking on them. We also accept that on a subsequent inspection by Dorset Fire service they noted that the fire door provision was appropriate in the home.
111. Having heard evidence from a number of inspectors and read reports from officers working for Dorset County Council, district nurses GPs and a consultant and noting their concerns we conclude that the professionals involved with Thislegate House have acted honestly and professionally.
112. We accept that throughout the inspections there has been praise for the care given to residents in the home. We do not dispute that that is the perception of the residents and the carers. We make the qualification that residents and relatives are not always aware of the extensive responsibilities of the provider. Also all the residents in the home from 2014 onwards have lacked capacity.
113. We conclude that the residents at Thistlegate House for the past six years have been very vulnerable adults. They have often had additional health and dementia issues. Most recently all of them have been assessed as lacking capacity.
114. We find that the care plans were not accurate or up-to-date or complete and have remained so over a period of 3 years. The way that the care plans were kept in many different places spread over different books, dairies and files is not conducive to proper planning and care for vulnerable residents. (Breach of regulation 10/17 and 9/9&12)
115. We also accept that medication recording had failed on occasion and there were tablets unaccounted for. (Breach of regulation 13/12)
116. We accept the point made by the respondents that even in a relatively small home written records are essential as oral instructions or recollections can very easily be misunderstood or forgotten.
117. As noted above Mr Corney represented himself. He brought no additional evidence or expert witness to support his case. We conclude that Mr Corney and Mrs Webb have shown an unwillingness to change and to keep up with current standards and the regulations, which are statutorily required to be observed by those running registered homes. Mr Corney also has an unmoveable conviction that he is right. We accept the respondents' submission that no conditions or additional time would rectify the shortcomings of the home.
118. Action plans have been asked for, completed late and not been complied with. Ultimately the proprietors have shown an unwillingness to

improve or change the way that they run the home. The situation has gone on for a long period of time.

119. Mr Corney in particular appears to have spent a huge amount of energy and time arguing with the regulatory bodies. He has convinced himself that he is right and, from his own evidence, said that he would not wish to run the home in any other way. We accept that it is more likely than not that the provision of care at the home would continue with its current overall judgement of inadequate.
120. We accept that the respondents have looked at alternative methods of enforcement but decided that the decision to cancel the registration is proportionate and justified. The failure to comply with the regulations has had an impact on the people being cared for, for example as recorded in the safeguarding findings.
121. On the evidence that we have read and heard we accept that there have been ongoing breaches of regulations and in the light of the appellants' fixed views about their certainty in their methods and their unwillingness to consider other professional advice we uphold the respondent's decision to cancel the appellant's registration.
122. We therefore dismiss the appeal.

APPEAL DISMISSED.
Our decision is unanimous

Maureen Roberts
Tribunal Judge
First-tier Tribunal (Health Education and Social Care)

Dated: 11 May 2016