

Care Standards

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

[2017] 3206.EY

Heard on

30 April 2018 – 4 May 2018 at Weston-Super-Mare County Court and Family Court.

9-12 July 2018, 22-25 January 2019, 5-7 February 2019 at Exeter Magistrates Court.

Panel Deliberations

14 March 2019

BEFORE
Mr H Khan (Judge)
Ms J Cross (Specialist Member)
Mr J Churchill (Specialist Member)

BETWEEN:

Serendipity (Devon) Ltd

Appellant

-v-

Ofsted

Respondent

DECISION

The Appeal

1. Serendipity (Devon) Ltd (“the Appellant”) appeals, pursuant to section 21 of the Care Standards Act 2000 (“the Act”), to the Tribunal against Ofsted’s (“the Respondent”) decision dated 23 November 2017 (“the Decision”). The decision was made under s.14 of the Act, to cancel the Appellant’s registration of its Residential Family Centre (“RFC”), based in Devon. It was made on the ground that the Appellant, as an “establishment or agency”, “is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements” (pursuant s.14 (1) (c) of the Act).

2. The Respondent also relies on a failure to comply with a Compliance Notice as a ground for cancellation of registration. Compliance Notices, had been served on the Appellant (on 7 July 2017 and 4 August 2017) and contained steps specified which were not met within the stipulated time frames (pursuant to the s.14(1) (ca) of the Act).

Attendance

3. The Appellant was represented by Mr David Pojur (Counsel). Mr Ian Jackson attended as an observer.
4. The Appellant's witnesses who attended the hearing and gave oral evidence were Ms Julie Jackson (Registered Manager and Company Director), Ms Claire Dunn (Resource Worker), Ms Louise Philips (Human Resource Manager), Ms Christine Freestone (Dialogue Consultancy) and Ms Carolyn Sinclair, (Office Administrator).
5. Ms Alice de Coverley (Counsel) represented the Respondent. Ms Chloe Williams (Paralegal), Ms Juliette Smith and Ms Janet Frazer attended as observers on various days.
6. The Respondent's witnesses who attended the hearing and gave oral evidence were Mr Steve Lowe (Social Care Regulatory Inspection Manager until 16 January 2018), Ms Kerry Fell (Social Care Compliance Inspector), Ms Christina Maddison (Social Care Regulatory Inspector), Ms Sarah Canto (Social Care Regulatory Inspector) and Ms Shirley Bailey (Senior Her Majesty's Inspector, Social Care).

Restricted reporting order

7. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the children or their parents in this case so as to protect their private lives.
8. We should add that both the Appellant and the Respondent made it clear at the hearing, through their legal representatives, that they did not object to the making of such order.

Late Evidence

9. The Tribunal was asked to admit various items of additional evidence by the Appellant and the Respondent at various stages of the hearing. Some of the evidence (as explained in our order dated 6 December 2018) was agreed) whilst the admission of some of the late evidence was disputed.
10. The piecemeal nature of the late evidence means that we do not propose to list each and every application made in this decision. We will

refer to any evidence which has formed part of our reasoning below. However, we have set out some of the issues to provide an illustration of the types of evidence that we were asked to admit.

11. The late evidence included the submission, by the Appellant, of two lever arch files on the first listed day for oral evidence of the hearing (on 1 May 2018) comprising of witness statement and exhibits of Ms Julie Jackson dated 25 April 2018. The additional late evidence also included an undated document signed by various staff members confirming their availability to work, an undated summary of the Appellant's main themes and a copy of an undated forward plan. Mr Pojur accepted, on the Appellant's behalf that that such evidence was late but submitted that it was relevant to the issues before the Tribunal.
12. Ms Coverley responded to this application by setting out that whilst the additional evidence maybe relevant, she was concerned that the Respondent would not have sufficient opportunity to consider the large number of additional documentation submitted as part of the late evidence. We acknowledged the Respondent's concerns. We expressed our disappointment that such evidence had not been filed earlier in the proceedings and pursuant to the earlier directions. This was despite the Appellant being legally represented. Although the first day of the hearing (30 April 2018) had been set down as a reading day, this was in respect of the original hearing bundles. The large volume of additional evidence resulted in the first listed day of the hearing for oral evidence (1 May 2018) being adjourned in order for such evidence to be considered by both the Respondent and the Tribunal. Ms de Coverley, having considered the additional late evidence, confirmed that the Respondent did not object to its inclusion.
13. The Respondent made an application to admit an updated statement of Ms Canto dated 5 July 2018. Although this application was opposed by the Appellant, we admitted the statement on the basis that it dealt with some of the issues which arose as a consequence of the Appellant's substantial body of late evidence referred to in the paragraph above.
14. We also dealt with late evidence in an application made in between the hearings (the period between July 18 and January 19). Our order dated 6 December 2018 admitted the agreed evidence and took into account that the Respondent opposed the witness statement of Ms Julie Jackson dated 5 October 2018 with various exhibits.
15. We acknowledged the Respondent's reasons which include that this evidence could protract proceedings even further and open the door to applications to introduce yet further evidence. However, we decided to admit this evidence as Ms Jackson was responding to the evidence the Tribunal had received from the Respondent's witnesses Ms Canto. Ms Jackson's statement set out her evidence. It identified the issues she proposed to raise and provided clarity as to her evidence. Whilst we acknowledge the Respondent's concerns, nevertheless, a written

statement from Ms Jackson allowed the Respondent to consider the evidence, well in advance, that Ms Jackson would give at the hearing and allow the Respondent to cross examine Ms Jackson in a focused way. The submissions on behalf of the Appellant made it clear that this was only evidence that the Appellant would seek to provide in her oral evidence.

16. Although we had made an order dated 6 December 2018 admitting the agreed late evidence and explaining our reasons for doing so and setting out our concerns about any further late evidence, at the reconvened hearing on 22 January 2019, the Appellant made an application to admit as late evidence a document entitled “Business Plan 2019”. The Respondent objected to this on the basis that there had to be a cut-off point for any evidence. We had documented our concerns in the order dated (as explained in our order dated 6 December 2018) about the number of late items. Whilst we acknowledged the Respondent’s objections, but given the passage of time since the hearing in July 2018, we allowed it to be admitted as late evidence as it set out the Appellant’s current position and plans.
17. On the last day of the oral hearing (7 February 2019), the Appellant made a further application to admit late additional evidence comprising of 31 pages. The evidence was correspondence between Tumblewood Community School (“Tumblewood”) (Ofsted URN: 132775) The Laurels, 4 Hawkeridge Road, Heywood, Westbury, Wiltshire, BA13 4LF and Ms Sarah Canto and Mr Bradley Simmons.
18. The Appellant submitted that the Tribunal should admit the additional evidence as it goes directly to the issue of integrity of the Inspectors. It was explained that an Application could not have been made sooner as Ms Jackson was the only witness that could properly speak on oath to this evidence, and was part heard in her own evidence at the relevant time. We acknowledged the Respondent’s objections and we also had reservations about the timing of this application given that it was accepted that a large number of the documents which formed part of the application were in the possession of Ms Jackson for over six months. However, whilst we expressed our dissatisfaction at the timing of the application, we admitted the late evidence and considered that any prejudice to the Respondent would be limited as both parties would be provided with an opportunity to make written submissions on the contents and their significance to these proceedings.
19. We admitted all the late evidence where its admission was agreed between the parties and it was relevant to the issues in dispute. Overall, we did admit all the late evidence (save for evidence provided post hearing and referred to below) that was disputed as it was relevant to the issues in the dispute.
20. In considering any late evidence, the Tribunal applied rule 15 and took into account the overriding objective as set out in rule 2 of the Tribunal

Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008.

The Appellant

21. The Appellant is a private limited company incorporated on 16 June 2009. The Appellant has two Directors, namely Mr Ian Jackson and Ms Julie Jackson. The registered company's address is 24 Victoria Road, Exmouth, Devon, EX8 1DW. The Appellant is a provider of a Residential Family Centre ("RFC"). RFCs are a type of social care provision regulated by the Respondent.
22. The Appellant was registered with the Commission for Social Care Inspection in 2006 and subsequently registered with the Respondent since 13 April 2012 to carry on the Serendipity Family Assessment Centre ("the setting").
23. The Appellant notified the Respondent that the Responsible Individual (RI) in the setting is Mr Ian Jackson. The RI is the person responsible for supervising the management of the RFC. Ms Julie Jackson is the Registered Manager.
24. The Appellant is registered to care for up to 6 families at a time. It provides a facility where families are sent for close observation and assessment of their parenting abilities over a period of time, usually in the context of care proceedings. The children who are cared for at the settings are particularly vulnerable and already seen by the Local Authority and the Family Court as being at risk of significant harm in their parent's care.

The Respondent

25. The Respondent is the body responsible for the regulation of children social care providers under the Care Standards Act 2000 and the various Regulations made under that act. RFCs are a type of social care provision regulated by the Respondent.

Residential Family Centres (RFC)

26. Residential Family Centres (RFC) are defined in section 4(2) of the Care Standards Act 2000, as establishments at which:
 - a) Accommodation is provided for children and their parents;
 - b) The parents' capacity to respond to the children's needs and to safeguard their welfare is monitored or assessed; and
 - c) The parents are given such advice, guidance and counselling as is considered necessary.
27. Those resident at an RFC, given the nature of their needs, are particularly vulnerable, requiring continuous support, observation and

assessment. Each resident parent requires a full and fair assessment of their parenting skills and capacity, and should be given individualised support, in line with their abilities, needs and background. Each resident child should feel protected and safe, and benefit from effective parenting. Parents and children with disabilities and particularly complex needs or vulnerabilities should have these fully recognised and taken into account.

28. The purpose of ordering an assessment is to give the parents what is usually a final opportunity to demonstrate whether they can safely meet the care needs of the child whilst being monitored and closely observed with the expectation that the RFC will intervene and safeguard the child if necessary. The family assessments take place usually in circumstances where the community-based assessment, where the child remains at home with the parent(s), is deemed to be too risky.
29. Providers of RFCs must, accordingly, comply with the requirements of The Care Standards Act 2000 (Registration) (England) Regulations 2010. They must also comply with The Residential Family Centres Regulations 2002 (hereafter, the “Regulations”). They are also expected to comply with the National Minimum Standards (“NMS”).

Events leading up to the issue of the Notice of Cancellation

30. There were a number of inspections carried out by the Respondent of the setting. These are as set out below.

Inspection (23 January 2014)

31. According to the Respondent, the setting was inspected on 23 January 2014 and given an overall grading of “Good”.

Inspection (20 – 22 June 2017)

32. Between the 20 and 22 June 2017 (“June Inspection”), the setting was inspected and graded as “Inadequate” in all areas. The Inspectors identified *“serious and widespread failures that mean children and parents are not protected or their welfare is not promoted or safeguarded and the care experiences of children and parents are poor.”*
33. Following this inspection, the Respondent concluded that the setting was not being run in accordance with the relevant requirements (the Residential Family Centre Regulations 2002) and requirements were made in respect of the following regulations:
 - Regulation 10 – Health and Welfare of Residents
 - Regulation 12 – Arrangements for the Protection of Children
 - Regulation 13 – Placements
 - Regulation 13A - Assessments

- Regulation 16 – Fitness of Workers
- Regulation 17 – Employment of Staff
- Regulation 19 – Records
- Regulation 20 – Complaints
- Regulation 21A – Use of surveillance
- Regulation 23 – Review of Quality of Care
- Regulation 25 – Visits by Registered Provider
- Regulation 26 – Notifiable Events

34. A set of actions required to be taken to meet the Act, the Regulations and the National Minimum Standards was included within the June Inspection report.

Compliance Notice (6 July 2017)

35. In respect of the breach of Regulation 13, a Compliance Notice (“July Compliance Notice”) was issued on 6 July 2017 and served under section 22A of the Care Standards Act 2000. This set out the legal requirements that the Respondent submitted the Appellant was failing/had failed to meet and the evidence to support the decision. The Compliance Notice set out the steps that the Appellant needed to take to remedy the failures including the timescales (by 21 July 2017) within which the Appellant was required to complete those actions. It is and was an offence not to comply with a Compliance Notice.

Monitoring Inspection (24 July 2017)

36. A monitoring inspection took place on the 24 July 2017 (“July Monitoring Inspection”). The Respondent concluded that the first Compliance Notice served following the inspection on 20-22 June 2017 remained unmet. The conclusion was that:

“There is evidence that some improvement has been made, but this work is not completed to a level that meets the requirements in the Compliance Notice.”

37. A second set of actions was required to be taken, replicating the first, was included within this July Monitoring Report, with revised dates to be completed. The requirements listed under Regulation 13 continued, following a case review, to be subject of a Compliance Notice.

Compliance Notice (4 August 2017)

38. A further Compliance Notice, dated 4 August 2017, was served and it was directed that this had be met by the 18 August 2017. According to the Respondent, this was done on the basis that it appeared to Respondent that some steps had been taken to try and address the shortfalls that had been identified in placement plans. The decision was taken that the Compliance Notice would be re-issued, allowing the

Appellant more time to address the failings and as an alternative to prosecution under the Act.

Inspection (22 and 23 August 2017)

39. A further full inspection of the setting took place on the 22 and 23 August 2017 (“August Inspection”). Following a second full inspection, dated 22 to 23 August 2017, the Appellant RFC was judged “Inadequate” in every area.
40. The setting continued to be carried on otherwise than in accordance with the requirements as set out in the Regulations. Ten requirements raised at the June inspection continued to be unmet. Requirements were made in respect of the following regulations:
- Regulation 10 – Health and Welfare of Residents
 - Regulation 12 – Arrangements for the Protection of Children
 - Regulation 13 – Placements
 - Regulation 13A - Assessments
 - Regulation 16 – Fitness of Workers
 - Regulation 20 – Complaints
 - Regulation 21A – Use of surveillance
 - Regulation 23 – Review of Quality of Care
41. The Compliance Notice was found not to be fully met.

Notice of Proposal (“NOP”) (8 September 2017)

42. A Notice of Proposal, under s.17 of the Act (“NOP”) dated 8 September 2017, was served on the Appellant providing reasons for the Respondent’s proposal to cancel registration under s.14(1)(c) and (ca) of the Act.

Notice Restricting Accommodation

43. The Notice of Proposal was raised in conjunction with a Notice Restricting Accommodation. This Notice Restricting Accommodation was not challenged and was extended again on 14 November 2017. It has been subsequently extended but was not subject to an appeal.

Monitoring Visit (21 September 2017)

44. A further monitoring visit took place on 21 September 2017 (“September Monitoring Visit”). At this stage, the Appellant had two families in the RFC. The conclusion was that:

“The monitoring visit found that some improvement has taken place since the previous inspection. However, serious concerns remain about the safety of the service and the quality of assessments.”

Monitoring Visit (30 October 2017)

45. A further monitoring visit took place on 30 October 2017 (“October Monitoring Visit”). At this stage, the Appellant had one family in the RFC. The Respondent’s conclusion was that:

“The outcome of this monitoring visit is that the service is not yet sufficiently evidencing embedded improvement that would give Ofsted the confidence to withdraw the notice of proposal to cancel the registration.”

Representation Panel (8 November 2017)

46. A Representations Panel took place on 8 November 2017 to consider written representations, pursuant to s.18 of the Act, provided by the Appellant dated 10 October 2017. These representations related to the Notice of Proposal issued to cancel the registration of the Appellant. The written representations fully accepted the concerns and shortfalls identified at inspections in 2017.
47. The Panel decided not to uphold the Appellant’s representations and to proceed to issue a Notice of Decision. In the view of the Respondent there remained insufficient evidence of the capacity to implement and sustain improvements, despite the assistance the Appellant had had from a second consultancy firm, Dialogue.

Notice of Decision (“NOD”) (23 November 2017)

48. The Notice of Decision to cancel was accordingly issued, dated 23 November 2017, pursuant to s. 19 of the Act. This is an appeal against that Notice of Decision.

Monitoring Visit (5 February 2018)

49. The Respondent attempted to carry out a monitoring visit of the setting but it was not possible to gain entry to the setting.

Monitoring Visit (20 February 2018)

50. The Respondent carried out a monitoring visit on 20 February 2018. The Respondent found that there were no families in residence and the Appellant was complying with the Restriction Notice. The Respondent concluded that it had not been presented with any evidence that demonstrated a readiness to operate at a level that meets the Residential Family Centre Regulations 2002.

The Respondent’s Position

51. The Respondent's position was that the Appellant, as an "establishment or agency", "is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements" (pursuant s.14 (1) (c) of the Act).
52. The Respondent also relied on a failure to comply with a Compliance Notice as a ground for cancellation of registration. Compliance Notices that had been served on the Appellant, contained steps specified which were not met within the stipulated time frames (pursuant to the s.14(1) (ca) of the Act).
53. The Respondent alleged that the following Regulations of 2002 Regulations were not met and formed the core basis of the decision to cancel registration in November 2017.
- Regulation 10 – Health and Welfare of Residents
 - Regulation 12 – Arrangements for the Protection of Children
 - Regulation 13 – Placements
 - Regulation 13A - Assessments
 - Regulation 16 - Fitness of Workers
 - Regulation 17- Employment of Staff
 - Regulation 20- Complaints
 - Regulation 23- Review of Quality of Care
 - Regulation 25-Visits by the Registered Provider
 - Regulation 26-Notifiable Events
54. Ms de Coverley submitted that Regulation 7 was also breached, as the Respondent was not confident in the professional abilities of the Registered Manager to manage the RFC. Regulation 15 was also currently breached as there is no staffing team currently employed at the setting.
55. The Respondent submitted that in terms of Regulations 21A – *surveillance* – and Regulation 19 – *records* – these have been included in the Scott Schedules as relevant factual background. These Regulations were not breached for the purposes of the November 2017 decision, but had been breached in the past. It was submitted by the Respondent that this can be evaluated in terms of the Appellant's overall compliance and they are also relevant to the issue of risk of repetition. These historic concerns were therefore still significant and relevant to suitability.

The Appellant's position in respect of the allegations.

56. The Appellant's position was set out in the skeleton argument prepared on its behalf by Mr Pojur. It set out that the enforcement action undertaken to close down the Appellant was neither proportionate nor necessary. The Notice of Decision should cease to have any effect and

the appeal be allowed. No admissions were made as to the Respondent's case.

57. The Appellant's position by the time of the hearing was that it denied the allegations in their entirety and any previous admissions were described by Mr Pojur as "*lapses*". In any event nothing which was previously admitted would constitute of practice being carried out on carried on otherwise than in accordance with the relevant requirements" (pursuant s.14 (1)).
58. The Appellant explained the reasons for the change of position. These included that at the time of the inadequate inspections, Serendipity had 6 families in placement and the Respondent raised significant concerns. The emphasis and focus was to continue to undertake assessment of the families in placement and also address the concerns raised by the Respondent. At this stage the Appellant accepted the concerns as they believed in the integrity of the regulator and that the inspection would have been undertaken without fear or favour.
59. It was only after the appeal decision in November 2017 when the number of families in placement had reduced and the Appellant was preparing documents for Tribunal, did it have time to focus on and begin to scrutinise all of the evidence. The Appellant submits that it began to discover the full extent of the inaccuracies, exaggerations and untruths in the reporting, by the Respondent's personnel. Upon understanding the same, the Appellant began to challenge the regulator.

Legal Framework

60. There was no dispute as to the applicable law as set out in the Respondent's response to the appeal dated 12 January 2018 and the skeleton. We have adopted the legal framework as set out in the Respondent's skeleton argument.
61. The legal framework for the registration and regulation of Residential Family Centres is found in Part II of the Care Standards Act 2000.
62. Residential family centres are defined in section 4(2) of the Act, as establishments at which:
 - a) accommodation is provided for children and their parents;
 - b) the parents' capacity to respond to the children's needs and to safeguard their welfare is monitored or assessed; and
 - c) the parents are given such advice, guidance and counselling as is considered necessary.
63. Providers of RFCs must, accordingly, comply with the requirements of the Care Standards Act 2000 (Registration) (England) Regulations 2010 ("2010 Regulations"). They must also comply with The Residential

Family Centres Regulations 2002 (hereafter, the “Regulations”). They are also expected to comply with the National Minimum Standards (“NMS”).

64. The provisions relevant to cancellation are set out below;

14.— Cancellation of registration.

(1) The registration authority may at any time cancel the registration of a person in respect of an establishment or agency—

... (c) on the ground that the establishment or agency is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements;

..(ca) on the ground that—

(i) a notice under section 22A relating to the establishment or agency has been served on that person or any other person; and

(ii) (ii) the person on whom the notice was served has failed to take the steps specified in that notice within the period so specified;

(3) In this section “relevant requirements” means—

(a) any requirements or conditions imposed by or under this Part; and

(b) the requirements of any other enactment which appear to the registration authority to be relevant.

65. Section 17 of the Act provides that, if it is proposed to cancel registration, the Respondent is required to give notice of the same and set out the reasons for the decision. Section 18 confers upon the Registered Person the right to make written representations in respect of the proposed action to be considered before the decision is made final. If the final decision is to cancel registration then, again, notice to the Registered Person must be given.

66. Section 21 of the 2000 Act provides a right of appeal to the Tribunal and the decision does not take effect until either the time limit for lodging an appeal expires, or if an appeal is so lodged, until the conclusion of the proceedings.

67. The legal burden of proof lies with the Respondent, who must establish the facts upon which it relies to support cancellation. It must also demonstrate that the decision to cancel the Appellant’s registration is proportionate and necessary.

68. The standard of proof to be applied is the “balance of probabilities”, in other words that the Tribunal must be satisfied that it is more likely than not, that the facts as asserted by the Respondent are true.

69. The Tribunal makes its decision on the basis of all the evidence available to it at the date of the hearing and is not restricted to matters

available to the Respondent when the cancellation decision was taken.

70. The powers of the Tribunal are set out in section 21 of the 2000 Act. The Tribunal may either confirm the Respondent's decision to cancel or direct that it shall not have effect. If the Tribunal decides that cancellation should not have effect, it may impose conditions on the registration, or vary or remove any of the current conditions.

Evidence

71. We took into account all the evidence that was presented in the hearing bundle and at the hearing. This includes all the statements from the Appellant's witnesses who were not required to attend the hearing to give oral evidence.
72. We have summarised the evidence insofar as it relates to the relevant issues before the Tribunal. We wish to make it clear that what is set out below is not, nor is it intended to be, a transcript of everything that was said or presented at the hearing.
73. Mr Lowe denied having a personal axe to grind with the Appellant. Mr Lowe explained the Social Care Common Inspection Framework and how he and other inspectors operate within it, and how it measures the impact on children and the quality of a service.
74. Mr Lowe set out that he became involved with the Appellant following the full inspection of the service in June 2017. Following this inspection, a case review was convened on 27 June 2017 at which he was the decision-maker. He explained that during the case review, a whole range of issues were considered.
75. He was concerned about the incident of the baby being roughly handled by its mother for a period of 20 minutes. In his view, it was clear that staff should have taken immediate steps to intervene and safeguard the baby's welfare in the circumstances but did not do so.
76. He was also concerned to hear that the Registered Manager, Ms Jackson had not adequately assessed the risk of admitting a parent with a history of violent conduct into the service. He explained that there was an expectation as set out in the Residential Family Centre Regulations 2002 that the Registered Provider and Registered Manager would fully risk assess each admission and how it would impact on the families who are already in residence and that, if appropriate, measures will be put in place to address any risks. At that inspection there was no evidence that this was taking place.
77. Mr Lowe explained that there was a "huge gap" in the paperwork for a child with a heart condition. He explained that he would expect this "*essential information*" to be in place for a baby who is critically ill, and if it was not in place, for the baby to stay where it was until it became

available. He explained that “the NMS are very clear” – “you have to have that information in place before they arrive and if that means putting pressure on other professionals, that must be done”. He was concerned that staff had not been instructed on how to respond to the needs of a baby with a heart condition. These needs were significant and, if not responded to appropriately had the potential to be life-threatening. He expected every member of staff to know exactly what to do if the baby became unwell as time was of the essence in such a case.

78. In his view, the Appellant was in breach of 12 Regulations contained in the Residential Family Centre Regulations 2002. The overarching theme of the breaches was that families and staff were not clear about what risk children were likely to be exposed to and what should happen to prevent harm or injury. Parents did not have a clear picture of what they were being assessed on, how, why or by whom. He explained that the assessment had been ordered by the Family Court because social workers have very real concerns about the safety of babies and children and assessments cannot be done in the community. The stakes for the parents and the children were very high as the outcome of the assessments was very likely to determine where the baby will live for the rest of its life. In the circumstances, he expected the parents to know clearly what was expected of them, when staff will step in to protect the baby, and what parents must do to demonstrate they are safe enough to take the baby home with them. These expectations were consistently not met at the setting.
79. Mr Lowe explained that he carefully considered what steps the Respondent would take in respect of those breaches. At the heart of the consideration was to ensure that children were kept safe and to improve the standard of care being given. He was aware that there was a range of action available to him.
80. He took the decision to issue a compliance notice under section 22A of the Care Standards Act 2000 in relation to regulation 13 of the Residential Family Centre Regulations 2002. The Compliance Notice was dated 6 July 2017. The aim of a Compliance Notice was to remedy this particular breach and required the Appellant to review all of the placement plans for the families. In particular, that all risks to children had to be identified and that staff had to be informed how to respond. In light of the rough handling of the baby that had been seen at the setting, the Appellant was compelled to ensure that staff and parents were clear about the levels of supervision and when staff would intervene. Mr Lowe explained that failure to take steps set out in a Compliance Notice may mean the provider is committing an offence and it may form the basis of the decision to cancel the registration. Mr Lowe considered that it was proportionate, at that stage, to issue the Compliance Notice in order to give the provider the opportunity to remedy this particular concern as soon as possible.

81. Mr Lowe attended the monitoring visit on 24 July 2017. He had two meetings with Ms Jackson at the start and end of the monitoring inspection. At the conclusion, she confirmed that she did not have any complaints to make about the process to date or the monitoring visit of 24 July 2017.
82. Mr Lowe confirmed that he was the decision-maker at the case review on 26 July 2017. He considered the new evidence which had been found. In his view, notwithstanding that a Compliance Notice had been served in order to address the issue of placement plans for families, the Appellant was still not compliant with regulation 13 of the 2002 Regulations. He made the decision to serve a further Compliance Notice. Mr Lowe explained that for the Respondent to issue a second Compliance Notice after the first had not been met, instead of taking other regulatory action, was unusual.
83. He was told that the Appellant had employed the services of a consultant who had helped them to make small improvements in the paperwork. This input had not yet resulted in the required standard of risk assessment or placement planning. However, he saw it as proportionate to give the Appellant more time to address the shortfalls. The second Compliance Notice was served on 4 August 2017 and gave the Appellant until 18 August 2017 to comply.
84. Mr Lowe was concerned about the failure to protect babies and children and therefore took the decision to join the re-inspection of the Appellant on 23 August 2017 so that he could see at first hand whether the concerns that the Inspectors had identified in June and July 2017 had been addressed.
85. On arrival, he found that on 18 August 2017, a seven-month-old baby at the setting had incurred an unexplained injury. The baby was seen by staff to have bruising to its leg, yet the matter had not been referred to the Registered Manager, the Local Authority, the Designated Officer for Safeguarding at the Local Authority or the Police. This baby had been identified as being at high risk of physical harm through rough handling by parents and therefore the discovery of such an injury should have triggered an immediate concern and referral. The Appellant's staff did not follow the child protection procedures. It was the mother of the child who discovered the bruise herself upon her return from Court on 18 August 2017. She made a complaint at that point as she maintained that the baby did not have the injury prior to her leaving the building, raising suspicions that a member of staff had caused the injury. No immediate referral was made to the Designated Officer for Safeguarding as would be expected.
86. On 19 and 20 August 2017, information about the bruise and the complaint was handed from one set of staff members to another with no referral to senior managers or to external bodies. Further at no point did the baby receive medical attention and the ability to establish medical

opinion on the cause of the bruising had been lost as time moved on. Throughout this period the potential for a member of staff who had harmed the baby to continue to have access to the family remained. Staff had yet again not followed their procedure. On 21 August 2017, the family moved to another setting and the foster carer that received the family also raised an alarm that the baby had a bruise on his leg that could not be explained.

87. Mr Lowe was very concerned that there had been significant failures to safeguard this baby by immediately referring the injuries appropriately. This was a particularly vulnerable baby at risk of physical abuse from its parents. It was extremely worrying that such concern had not been acted upon, particularly as the family were moved to another setting and therefore such failures and inaction had potentially exposed the baby to a serious risk of harm. Mr Lowe submitted that another possible explanation was a member of staff had caused injury to the baby and the opportunity to thoroughly investigate the circumstances of the injury had been lost.
88. Mr Lowe was even more concerned to witness a Social Worker, Ms Pippa Hector, employed by the Appellant beginning to review CCTV footage and conduct an investigation into how the bruise happened. In his view, at this stage, it was possible that the parent or member of the Appellant's staff had caused the injury and therefore this investigation should not have been undertaken by another employee of the service without independent scrutiny from the Designated Officer of the Local Authority. He explained that this is a fundamental principle of good safeguarding practice and, for a setting entrusted to safeguard children at very real risk of harm to get this so wrong, was very alarming. He was aware that the Social Worker employed by the Appellant had been asked by Ms Maddison to stop the investigation on two separate occasions but she had continued. At this point, he himself had instructed the Social Worker to cease the investigation immediately. This was particularly significant given that the Social Worker had failed to comply with the Appellant's own child protection procedures.
89. In his view, the Social Worker who started an internal investigation into the injury of the baby had demonstrated incompetence and the Registered Manager had acknowledged this sequence of events as wholly unacceptable. Furthermore, the impact of every staff member who was charged with following child protection procedures failing to do so was that a seven month old baby was injured and nobody knew how or at whose hand.
90. In his view, a service of this nature, where safeguarding was their core business, this failure to protect was evidence that the service was not competent in understanding basic child protection processes.
91. Mr Lowe also observed that in the placement plan for one family, a mother was recorded as having to take medication to keep calm and

that she was seeing a psychiatrist and had a history of self-harm. The placement plan however, contained no details as to how these potential risks to the baby in her care were to be addressed or what staff should do if the mother displayed concerning behaviour associated with her mental health. This concern was all the more acute at the time as the setting had a high level of agency staff who would be relying on information set out in the placement plan which was, in his view inadequate to address the risks the mother presented to the baby and the steps to be taken to mitigate those risks.

92. Mr Lowe felt that the latitude that he had agreed to give following the first monitoring visit had not resulted in any significant change the service. Mr Lowe was so concerned about the potential risk of harm to children that he requested one of Her Majesty's Senior Inspectors (Mr Paul Fletcher) to be the decision-maker at the subsequent case conference on 24 August 2017 so that the full range of enforcement action available could be considered. Of the 12 regulations identified at the inspection on 20-22 June 2017, the Appellant was still not complying with nine of them. The Compliance Notice was also not met.
93. Mr Paul Fletcher made the decision, which Mr Lowe agreed with, to restrict the number of families that were resident at the RFC to those that were already there. This decision was taken as a new company of safeguarding consultants were to be involved in scrutinising every potential incident. The remaining families were partway through a finely balanced assessment that had been ordered by the Family Court. In his view, the decision not to suspend the service was a proportionate one that allowed the families to complete their assessments, with external safeguards in place.
94. Mr Lowe set out that he was the decision-maker at the subsequent case review which took place on 25 September 2017. Serious safeguarding concerns remained. For example, he was presented with evidence about an incident where the consultant employed by the setting had to prompt the RFC's Registered Manager to report a matter in line with safeguarding procedures. In his view, this was compelling evidence that the Registered Manager and the staff had neither the capacity nor the ability to follow basic child protection principles consistently. He was concerned that even with the assistance from the consultant and in the presence of the Respondent's inspectors they were still making the same mistakes. This left him with no confidence that the setting can make improvements in practice necessary to safeguard children from harm.
95. A further monitoring visit took place on 30 October, when there was only one family in residence. Inspectors discovered that once again staff had failed to intervene and a baby suffered a mark to its head as a result.
96. Mr Lowe attended the representations panel on 8 November 2017 where the Appellant's submission relating to the Notice of Proposal to

cancel was heard. He confirmed that all the representations were considered. He was in agreement that there was insufficient evidence to withdraw the notice and agreed with the decision to proceed to a Notice of Decision to cancel the registration.

97. A key factor in reaching this decision was that the improvements made by the Appellant were largely procedural and there had been some additional safeguarding training provided to staff. The consultants being used were still acting as a safety net to catch potential safeguarding breaches. The significant failings that he had witnessed were attributable to people not procedures. He was not satisfied and did not have confidence that the people who run the setting had the capacity to keep babies and children safe without the scrutiny of the Regulator and the support of external consultants.
98. In his view, a proportionate response had been taken by the Respondent at each juncture to enable families to complete the remaining assessments ordered by the Family Court, with external safeguards in place whilst the Respondent pursued enforcement action.
99. Mr Lowe also set out that he attended the monitoring visit on the 20th February 2018. The purpose of this visit was to establish whether the Appellant had complied with the notice restricting admissions. There were no families in residence at the time. Ms Jackson was happy for the inspection to be completed given that she was unwell and had been declared as unfit to work by a doctor. The last family had left on 15 December 2017 and their assessment was not available for scrutiny and evaluation as it had been sent to the Local Authority. Apart from one member of staff who was still on maternity leave, the permanent staff been made redundant.
100. In addition to the Registered Manager, three members of staff were present on the day of the inspection all of whom were being paid on a sessional basis. Ms Jackson showed him documents which contained alternative uses of the building. Ms Jackson confirmed that she was not in a position to run the centre at the time because of ill health. He was not presented with any evidence that the 2002 Regulations were being met.
101. The documentation provided by the Appellant was reviewed by Mr Lowe during cross examination. These documents included risk assessments, placement plans, draft reports, weekly updates to the LA, a parent booklet and referral forms. He confirmed that he had read these documents for the purposes of the representation panel.
102. Mr Lowe had read and evaluated each of the 10 monitoring reports submitted to the Respondent by Ms Christine Freestone from Dialogue. These related to the visits she made to the setting between 22 September 2017 and 8 December 2017. The report detailed the changes in processing paperwork that the Appellant undertook under

the guidance of Dialogue. In his view, because the Appellant's managers and staff had made so many significant safeguarding errors, it was the Respondent's view that Dialogue were operating as a "safety net" and evaluating every potential safeguarding incident. For example, Mr Woodhouse of Dialogue had picked up one incident where the Registered Manager had not followed proper safeguarding procedures.

103. He set out that Ms Freestone had confirmed in her report that she was unable to perform the "safety net" function during her visits as she had not been able to gain consent from the Local Authority to look at family records. She only reported on what the Registered Manager told her. Given that the Registered Manager had made safeguarding errors herself, this lack of scrutiny gave him additional cause for concern. This resulted in no independent assessment of safeguarding issues for approximately two months.
104. Mr Lowe made reference that in the final Dialogue monitoring report dated 8 December 2017, Ms Freestone concludes by saying that many of the revised processes cannot be fully tested at this point and that there will need to be an ongoing review to test whether culture and practice had changed sufficiently to meet all compliance and practice requirements. He agreed with that view.
105. Furthermore, Ms Freestone viewed the quality assurance report required by regulation 25 of the 2002 regulations as key to this testing. Her report states that the next regulation 25 report for November 2017 would be submitted to the Regulator. However, this was never received and there have been no further quality assurance reports submitted to date.
106. In his view, at a time where safeguarding practice had been severely criticised, the independent consultant had not scrutinised essential records. There had been no quality assurance reports since Dialogue's involvement with the Appellant. This gave him little confidence about the Appellant's capacity to change, improve and sustain a safe environment for vulnerable babies and their families.
107. Mr Lowe commented on some of the documentation during cross examination. The interim report dated 13 June 2017 relating to SB was described as poor quality, particularly because of the lack of detail on attachment, which he described as "core business for social work" and the lack of early, available conclusions at a four-week stage.
108. Furthermore, Mr Lowe accepted that whilst there had been no judicial criticism from the Family Court of the delay in assessments, he had observed that there had been adrift and delay in almost every written assessment. This resulted in applications being made to the court for extra time and he explained how such a delay would make it impossible for a court to refuse an extension of time. In his view, meaningful assessments were not starting until week 4 or 5, which impacted on a

child. For example, the report dated 28 July 2017 (H526) recommended time for further assessment instead of concluding a 12 week assessment.

109. He was concerned that Ms Jackson had put her name to one of the reports when she should not have done so as she was not a social worker (Report dated 20 September 2017 relating to AL/BD).
110. Mr Lowe explained how he offered to make additional quality assurance visits to give Ms Jackson the ability to speak at any time. He did not think there was hope that the individuals who were registered to run the establishment at the present time could keep the place safe to run. Further, being unable to learn, he said, was a key failing of the Appellant. In his view, "the failure to take accountability endures".
111. Ms Kerry Fell, confirmed she has oversight for all compliance and activities in the South West region. She was also responsible for notifying the Appellant about the representations panel and was a minute taker during the representations panel. However, she made it clear that she was not the decision-maker and had no influence over the decision being made.
112. Ms Fell explained how the Care Standards Act 2000 at Section 18 allows "written representations" to OFSTED concerning any matter which that person wishes to dispute. The Notice of Decision was clear about the right to appeal and to make representations, advising individuals to look at policies, procedures and the OFSTED website.
113. Ms Maddison set out that she did not have any axe to grind with the Appellant or any of its staff including Ms Jackson. Ms Maddison stated that she had previously had some involvement with the Appellant as a concern had been brought to her attention regarding the employment of Ms Jackson's son, Mr Reid. However, she had investigated the gaps in Mr Reid's employment history and been satisfied that the issue had been dealt with. She had been invited to a meeting at Devon County Council as a concern had been raised by Mr Reid's previous employer and she had attended the meeting and informed them of her previous involvement and the fact that the Respondent had considered that issue closed.
114. Ms Maddison set out that she had been the lead inspector on six inspection visits to the Appellant since 20 June 2017. These visits took place on the following dates:
 - A full inspection 20 -22 June 2017 (Sarah Canto -was the second inspector).
 - A second full inspection on 22-23 August 2017 (Sarah Canto was the second inspector on the 22 August 2017 and Steve Lowe was the second inspector on the 23 August 2017).

- She led the monitoring visits on 24 July 2017, (where Steve Lowe & Sarah Canto were the second inspectors), 21 September 2017, and 30 October 2017 (where Sarah Canto was the second inspector).
115. Ms Maddison confirmed that the judgement for the June inspection was “*Inadequate*” across all areas. Sixteen requirements were made under twelve separate regulations. A Compliance Notice was issued following this inspection. Ms Maddison explained that full inspections of family centres are usually conducted over two days. However, due to the extensive and serious shortfalls found, and in order to give the Registered Manager time to produce extra evidence, the inspection was extended by one day.
116. Ms Maddison undertook the role of scrutinising health care plans. She found that a baby with complex health care needs had been admitted on the 7th June 2017. The baby’s health care needs, and how the staff should support the baby to ensure its safety and wellbeing were not identified and documented in the health care plans. This meant the staff did not receive the guidance and strategies they needed to ensure that all of the baby’s health needs were safely and comprehensively met. This shortfall left the baby at risk of harm as the staff were not given guidance about what action they should take in the event of a medical emergency with this baby.
117. On another occasion the baby was admitted to hospital. This incident was not notified to Respondent as required by Regulation 26 of the Residential Family Centre Regulations 2002. The Respondent must be notified of all serious incidents such as this, to ensure that the regulator has an overview of any serious incidents that may prompt an early inspection if there are concerns about the actions a service has taken to respond to the serious incident.
118. Ms Maddison was alarmed to read a report in the records that the staff did not promptly intervene to ensure the safety of a baby. In one incident on the 5 May 2017, the parent was observed by the staff to be roughly handling their baby over a period of twenty minutes despite known concerns about this parent’s safe handling of their baby. The staff were observing the parent and baby on CCTV failed to intervene, despite recording her distress in the log. Ms Maddison expected that the staff who were observing the parent and baby on CCTV to intervene but they did not do so, despite recording in the log: *‘it is clear the mother hurt the baby and had not responded to her distress.’* Ms Maddison would expect that the staff would intervene promptly and in line with guidance contained in individual risk assessments and plans to ensure the safety and well-being of a baby.
119. Ms Maddison was concerned to see an entry in the records relating to 3rd April 2017 that there was no interaction between a parent and baby when the baby was crying and it was twenty minutes before the staff intervened, causing the baby unnecessary distress. Ms Maddison would

expect that the staff would intervene promptly and in line with guidance to ensure the safety and well-being of a baby. Staff again failed to do so on this occasion.

120. Ms Maddison was concerned that plans did not detail what time should elapse before a member of staff should intervene if a member of staff was concerned about the safety and welfare of a child. A decision of when staff should intervene is a balanced one that requires skill, knowledge and experience by the person making the decision, which should be made in conjunction with the placing authority, of gaining evidence to inform the assessment, but ensuring that the child is not harmed emotionally, sexually or physically. It was a serious omission that staff were not receiving this guidance and it was up to them if they should intervene and at what point, if they observed a child being harmed.
121. Ms Maddison found that comprehensive individual risk assessments were not in place that would give staff strategies and document control measures to effectively manage risks. Ms Maddison was concerned to find that prior to the admission of families, a comprehensive risk assessment of any potential risks posed by individual families to themselves or others was not undertaken. Managers failed to undertake comprehensive impact risk assessments that detailed the potential risks of the admitted family to other families and how these were to be safely managed. One parent was found to have a history of violence. Ms Maddison found it very concerning that no consideration of the possible risk of this parent to the other families and children had been undertaken by managers at the setting and how this risk would be managed.
122. Ms Maddison requested the records of staff supervision three times from the staff on duty. She had to go to the office to obtain these documents. It was very concerning that no records of staff supervision could be found by the staff. The lack of supervision records led her to conclude that supervision of staff by the manager was not taking place on a regular basis. This view was supported by a member of staff who confirmed that the formal supervision of staff did not regularly take place.
123. She subsequently received an email on 14 September 2017 from a former member of staff about the issue of supervision. It stated as follows:

"Staff supervision - this isn't regular for anyone (resource/intervention/social workers)"

124. Ms Maddison found that leaders and managers had failed to notify Respondent on a further two occasions, as required by the regulations,

- when children were admitted to hospital in an emergency as required by Regulation 26.
125. Ms Maddison had also scrutinised an assessment of parenting and found that it did not contain in depth assessment and analysis of the quality of attachment between the parent and child. The assessment of attachment between a parent and child is a significant issue when assessing parenting capability. It is essential to understand attachment because, if not, then an individual may not recognise the importance of patterns of interactions between the parent and child, that may influence a final recommendation relating to the parenting assessment.
 126. Ms Maddison had found that a parent and child had been resident in the family centre since 18 January 2017. They had been admitted for a twelve week assessment of their parenting. Ms Maddison was concerned to find that the family were still resident at the date of the inspection (20-22 June 2017). The case management order from the court dated 26 May 2017 was looked at. The record indicated that the ending of the placement had been held up due to a delay in receiving an exit strategy from setting. Therefore, following the end of their twelve week parenting assessment, the family were allowed to drift and remain at the setting with no clear plan of work in place. This was concerning as plans for children should not be subject to drift and delay, as it is crucial that they are settled in a permanent situation as soon as possible. Managers failed to understand the importance of the detrimental impact on a child of drift and delay and put in place an exit strategy for this family.
 127. Ms Maddison led the monitoring inspection on the 24 July 2017 (with Sarah Canto and Steve Lowe), to monitor the Compliance Notice relating to Regulation 13(1)(a)(b) that was issued following the previous inspection of 20- 22 June 2017.
 128. She scrutinised placement plans once again. Plans were still not sufficiently individualised and only contained generic information. There continued to be a lack of focus on attachment issues. One placement plan was found to be out of date and did not give the staff clear direction about how long a parent was permitted to hold their baby for each day. Plans contained no evidence that parents were involved in writing them, or that they had been a part of deciding what the aims and objectives were, so that the families clearly understood what they were working towards and the steps needed to achieve the aims and objectives of their parenting assessment.
 129. Ms Maddison also scrutinised the risk assessment documents in place for each family. She found that the form had been revised and improved, but was concerned to find that these documents were not yet completed for each family, meaning a comprehensive assessment of risks associated with each family and how staff should safely manage these risks had not yet been fully considered. This shortfall also meant

that information that should inform supervision levels for each family were not in place.

130. Health care plans were incomplete. These important documents were described by a member of staff as being a “work in progress.’ Ms Maddison was concerned that this meant that parents and children with health care needs were at risk of not having their health care needs met as staff still did not have the guidance and strategies that they needed.
131. It was agreed at the case review following this monitoring visit, that the Compliance Notice issued at the full inspection was not yet met. However, some steps had been taken by leaders and managers to address the extensive shortfalls, and the decision was made to re-issue the Compliance Notice to effectively allow the managers more time to implement improvement.
132. On 22 and 23 August 2017 she led a second full inspection of the service. Ms Maddison set out that significant, serious and widespread shortfalls were again found at this inspection and the Compliance Notice was again found to be not met. It was found that the Appellant was meeting regulations 17 (staff supervision), 19 (records of who was living at the centre), 21A (CCTV surveillance/privacy), 25 (monitoring reports) and 26 (notification to Ofsted of significant incidents). However, the judgement of this second full inspection was that Appellant remained Inadequate in all judgement areas.
133. Ms Maddison explained that in one placement plan the parent had access to, unprofessional language was used. The plan stated to the parent: *'you have a learning disability and this makes it more difficult for you to care for your child.'* Another section stating why professionals were concerned and why the family was attending an assessment of their parenting stated: *you were not able to look after your first child safely, so you will not be able to look after this child well enough.'* In her view this was a very negative and judgemental language to use with a vulnerable parent and did not encourage and give a parent confidence, or start the assessment of their parenting from a strengths basis.
134. Ms Maddison found that the plans continued to lack clarity and failed to identify progress, or the steps the family needed to take and achieve, in order to progress to less supervision of their parenting and to identify any improvement they had made while undertaking their parenting assessment.
135. Management oversight and robust governance of the RFC continued to be poor. Ms Maddison requested the development plan to provide evidence of how the managers intended to deal with the identified shortfalls and demonstrate what they understood to be the strengths and weaknesses of the service. However, she was told that by the Consultant that a development plan was not yet in place.

136. Ms Maddison was very concerned to discover that managers and the staff failed to implement child protection policies and procedures, leaving a seven month old baby with an injury and at risk of harm. This breach was highlighted after the parent made a formal complaint to the Appellant on the 21 August 2017 as they left the service to move to a foster placement.
137. A member of staff needed to be told twice by Ms Maddison and again by Steve Lowe to stop investigating the incident. The injury was finally referred to the LADO by the service on 23 August 2017. This referral was five days after the injury was noted in the logs by the staff, so essential evidence was potentially lost to establish how the injury had been caused and/or possibly by whom, with the baby and possibly other children remaining exposed to that risk of harm throughout.
138. Ms Maddison found that when the bruise on the baby was discovered by the staff on duty on the 18 August 2017, they failed to obtain a medical examination for the baby to determine if medical treatment was necessary and to gather further evidence about the injury. This meant that the baby may have had a serious injury that required treatment and the manager and staff failed to obtain this treatment.
139. Ms Maddison had examined the daily logs and was very concerned to find that a parent had woken their child up at 9.05pm and decided to bathe the child. There was no evidence that the staff intervened and challenged the parent about waking up the child, or considered the negative impact on the child of their parent disrupting their sleep and bedtime routine. In her view, it was important for parents to learn to establish routines for babies, as the parents referred for parenting assessments will often live chaotic lives in the community.
140. Ms Maddison was also very concerned to learn that during a discussion with the consultant employed by the setting, that he needed to prompt the Registered Manager to report an injury to a baby that occurred on 20 September 2017, in line with child protection policy and procedures, as the Registered manager dismissed the injury as "*tiny*". It was very concerning to discover that without this consultant providing close scrutiny of any safeguarding concerns and reviewing every decision that the staff and manager were making, that the Registered Manager, who is the safeguarding lead for the RFC, would minimise concerns, attempt to investigate themselves and fail to report safeguarding concerns in line with safeguarding and child protection procedures, leaving parents and children potentially at risk of harm. Even though a new flow chart for reporting child protection concerns had been devised by the consultants, the manager and staff were still failing to follow them. This gave her serious concern that without the intervention and support of the consultant, the manager and staff would continue not to report injuries sustained by the children in their care.

141. Ms Maddison found that qualified social work staff reported that they were receiving supervision from the Registered Manager, who is not herself a qualified social worker. The regulations state that supervision must be carried out by a "suitably qualified person". As the assessment report being carried out for the family court must be delivered by a qualified social worker, the Registered Manager was not a suitably qualified person to carry out that supervision as she is not qualified to carry out the assessment work that she was supervising. A supervision record from 7 September 2017 for a social worker member of staff was scrutinised and she found that the session only covered basic daily issues, and there was no indepth discussion of professional issues regarding the families undertaking assessment.
142. Ms Maddison found that that the staff had failed to intervene and safeguard a baby, when a parent placed the baby on a changing mat on the floor too close to a radiator in the bathroom. The staff failed to observe that the baby was too close to the radiator and failed to intervene. The baby wriggled and the baby's head made contact with the radiator, leaving a red mark. The baby was described by a member of staff as crying 'breathily.' Following this incident there was no de-brief of the staff by managers regarding what they could have done differently or what they learned from the incident, to ensure that the incident was not repeated.
143. The setting is required to submit to the Respondent monthly monitoring reports in order to evidence that there is robust governance at the setting. The last monitoring report received by Ofsted was for October 2017. No further reports have been received as required under Regulation 25 of the Residential Family Centre Regulations 2002. This failure to report means that the Respondent was unable to ascertain whether there have been improvements implemented.
144. In her view there was insufficient evidence to assure the Respondent that the service is safe for parents and children or that there is the capacity to improve and sustain improvements.
145. On 5 February 2018 a monitoring visit was scheduled. However, entry could not be gained to the setting.
146. Ms S Canto denied having any axe to grind with the Appellant or its staff. She set out that she found significant shortfalls relating to safety of parents and children, placement planning and assessments. She found placement planning documents to be of a poor quality. Risks were either not identified or not clearly set out. Strategies were not in place to help staff to manage potential risk to children. Supervision arrangements were unclear especially during night time. Some information on the placement plan was incorrect. For example, one plan stated that the parent had a personality disorder. However, when she asked questions about this she discovered that there had been no diagnosis and it was self-reported.

147. Furthermore, Ms Canto found that the manager did not have all the letters of instruction for the parents and children resident in the setting. Staff were not clear which letters of instructions they did have. Staff were sending written feedback to local authority social workers, but most parents were not shown this feedback and therefore their views were not included.
148. In Ms Canto's view, it was particularly important for parents who came to a family centre for assessment to be clear about what the concerns were and what they needed to do to demonstrate their parenting was "good enough". The quality of the assessment report was variable. Reports gave very little mention to attachment which was a crucial part of understanding the relationship between a parent and a baby. Social workers had not had sufficient training on attachment.
149. We heard from Ms S Bailey. She had chaired the Representations Panel on 8 November 2017 to consider the written representations from the Appellant which were sent to the Respondent on 10 October 2017. The Panel was comprised of Ms Bailey, Steve Lowe and Ms Kerry Fell. Ms Bailey made it clear that she was the decision-maker and took into account the bundle of documents that the Appellant had submitted.
150. Ms Bailey confirmed that it was the Respondents procedure at the time for the matter to be considered by way of written representations. This was in accordance with section 18 of the Care Standards Act 2000. She had sent a link containing the information to the Appellant regarding the representations hearing. It was upto the Appellant to request to attend the Representations Panel. If the Appellant attended such an oral hearing, the Representations Panel would not seek to engage in dialogue regarding the representations but would only seek clarification about the representations submitted.
151. Ms Bailey was aware that the Appellant had lodged an appeal in November 2017 with the Respondents complaint team. Ms Bailey set out that she was aware of another complaint from another provider (Tumblewood) but it was her understanding this had been withdrawn prior to an investigation.
152. Ms Bailey had been aware that the Appellant had raised issues with regards to conduct of one of its inspectors, Ms Maddison. Although Ms Bailey had complete confidence in Ms Maddison, she acknowledged that there had been a breakdown in communication and arranged for Ms Madison not to be part of any further monitoring visit (i.e. the one on 20 February 2018). Ms Bailey had done so in order to move matters forward.
153. Ms Bailey confirmed that it was her understanding that the representations from the Appellant fully accepted the concerns and shortfalls identified at inspections/monitoring visits in 2017. The

Appellant had engaged a new consultancy to provide guidance and this consultancy had provided training to leaders, managers and staff in relation to safeguarding, recording and risk assessment. It was also her understanding that policies and procedures in relation to safeguarding had been reviewed and the risk assessment had been reviewed and updated.

154. Ms Bailey also took into account that an undertaking was given that a range of additional steps would be implemented should the panel decide to uphold the representations. These included Koru House remaining closed until 2018 and that only Serendipity House would accept families in order to ensure that the new procedures were effective. However, these changes were dependent upon the Appellant's representations being upheld
155. Ms Bailey set out that whilst she took into account the positive changes to written policies and procedures, her concern was that effectiveness of these actions was yet to be tested. In particular, there was a history of staff failing to follow procedures that had resulted both in an unexplained injury to a child being appropriately reported and on occasions failing to intervene to prevent accidental injury to a child.
156. Ms Jackson confirmed that she was the Registered Manager of the RFC. She was a director and responsible for the funding, setting up running and development of the company and the centre since it first gained registration in 2006.
157. She was extremely passionate about this work. She and her husband had made a personal sacrifice when setting up the RFC by moving out of the setting which had been their home at the time.
158. On 20 June 2017, she was on annual leave when she received a call from Ms S Apps (her staff member) to say that the Respondent's inspectors had arrived for an inspection. She explained to Ms Apps that the inspectors would want to see the folders, speak to residents and staff. Ms Apps was aware that information was kept in a drawer ready for an OFSTED inspection.
159. Ms Jackson set out that Ms Maddison had called her shortly thereafter and she had explained to her that there were jammed in a one-way queue to campervan fields at Glastonbury and were not able to return immediately but that Ms Apps, Operational Social Worker would be the designated person and she would assist and direct the staff regarding what was required for the inspection. Ms Jackson confirmed that she then arranged to return to the RFC after the ticketing gates were opened the following day.
160. Ms Jackson set out that Ms Maddison reminded her that they had met before as she had visited the setting to follow up a safeguarding

concern, which involved checking recruitment records and interviewing a staff member, namely, her son, Brian Reid.

161. Ms Jackson stated that following this inspection, she had received "*thorough feedback*" which focused on the negative. Ms Jackson set out that she walked to the desk in the room where drinking water was placed on a tray. She needed a drink of water and turned around and saw that Ms Maddison had written that she was obstructing the inspection. She denied that she was being obstructive.
162. Ms Jackson acknowledged that it was difficult for her to hear that the inspection findings resulted in an "Inadequate" judgement and felt a sense of shock which was reflected in the responses of the staff team who were equally devastated when they heard this judgement.
163. On reflection, she realised that Ms Pippa Hector had not understood, or properly considered the amended Ofsted inspection guidelines for inspection. Ms Pippa Hector had considered that the Appellant was up to date with its practice and had informed Ms Jackson that they were ready for an inspection. Ms Jackson acknowledged that she needed to have verified the findings herself but did not do so. She trusted Ms Hector's judgement.
164. Ms Jackson set out that relationships with the previous inspector, Ms Jennifer Reid were good. This resulted in a rating of "Good" by Ofsted in 2014. The Appellant was rated as "Excellent" in relation to safeguarding. In her view, the Appellant had improved from that. They did not expect an inadequate judgement. Her relationship with the current Ofsted inspectors who had visited the premises were not good and she had no faith in them.
165. Ms Jackson stated that the previous inspector, Jennifer Reid had said that the Appellant was ahead of the game. Accordingly, Ms Jackson expected a rating of "Good". However, Ms Jackson accepted in 2014 that the inspection report stated that the Appellant had not kept up to date with new legislation. She believed that she had employed the right people for the right job. This was not her area of expertise. However, Ms Jackson accepted that the Registered Manager was responsible for many matters including compliance with legislation.
166. Ms Jackson accepted that on the Appellant's website, it contained references to the 2014 inspection rather than the most recent inspections (in 2017). This was not an attempt to mislead. It was simply to make those from the outside aware that there was a dispute with the Respondent.
167. Ms Jackson set out that she stood by the information she had provided. She was confident in reopening the RFC. She mentioned that the Appellant had considered other options which did not involve regulatory

use. They had a meeting with Devon County Council to discuss such uses.

168. However, Ms Jackson set out that she was frightened, not with regards to her own capability, but how the Appellant would rebuild its relationship with the Respondent. She was not the sort of person who was frightened easily.
169. She said that the knowing what she knew about the other provider's (Tumblewood) matter and listening to the evidence of South-West Team, she felt that the Respondent's position was that the Appellant could reopen, but not with her. She drew an analogy with a paper cup saying that Respondent's position was that they were saying "*yes it's a good paper cup but not if it belongs to Ms Jackson*". Most of her previous staff have said that they would be back if she reopened.
170. She questioned the accuracy of the Respondent's conclusions. For example, the Respondent had removed the word "hot" from the report as part of the factual accuracy process. The inspector had told her that she could not attend the Representations Panel. Furthermore, the Appellant did not receive the inspection report (dated June 2017) until the monitoring inspection in July 2017 due to it being sent to the wrong email address. In her view, this will have impacted on the Appellant's ability to address the perceived concerns and was not mentioned in the subsequent monitoring report. She could not see how the RFC's relationship could be mended moving forward especially with the South-West team.
171. Ms Jackson accepted that the letter from Devon County Council dated April 2017 made no reference to the Respondent or to Ms Maddison.
172. Ms Jackson confirmed that they had not appealed the various Notices of Restriction. This was because it had no faith in the South-West Ofsted team.
173. Ms Jackson submitted that at the time of the inadequate inspections in 2017, the Appellant had 6 families in placement and the Respondent raised significant concerns. The emphasis and focus of the Appellant was to continue to undertake assessments of the families in placement and also to address the concerns raised by Ofsted. At this stage the Appellant accepted the concerns as they believed in the integrity of the regulator and that the inspection would have been undertaken without fear or favour. The Appellant responded to many concerns raised by the inspectors' interpretation of the NMS and regulations comprehensively, at the time, whilst fully accepting that it must be wrong, because the regulator said so. Mrs Jackson believed that the inspectors have not acted in accordance with their own guidance 'Conduct during Ofsted inspections'.

174. Ms Jackson explained that the written representations for the Representations Panel on 8 November 2017 had been prepared with the staff. She accepted that at that point that the Appellant and its staff needed to make significant improvements to paperwork and practice “across-the-board” in order to demonstrate compliance with multiple regulations.
175. However, Ms Jackson set out that following the Representations Panel in November 2017, when the number of families in the placement had reduced, the Appellant began to scrutinise all the evidence and discovered the full extent of the inaccuracies exaggerations and untruths in the reporting by the Respondent’s personnel.
176. Ms Jackson accepted that the safeguarding incident in August 2017 was unacceptable, as was the Appellants response in dealing with it.
177. Ms Jackson responded to Mr Lowe’s criticism of the RFC of when the baby with the heart condition arrived at the RFC. She accepted that the baby should have arrived with the social worker along with all of the required paperwork. However, she accepted that this did not happen and but it was not the fault of the setting. Prior to admission the Appellant had the initial search information sent out by the commissioning team which outlined the concerns and risks in relation to the family which was quite comprehensive information. The Appellant’s paperwork was emailed to the commissioning team to be passed to the social worker prior to the family’s admission and it was understood that this should be sent back prior to the family being admitted to the centre. Mrs Jackson received reassurances both verbal and written from the LA that this would happen.
178. The family arrived into placement at 7pm, despite being expected earlier in the afternoon. They were not accompanied by the Social Worker and the Appellant’s paperwork had not been completed as expected. The journey from Swansea had been long and arduous for the family. The parents were extremely distressed and anxious. Consequently, the emphasis was to settle them into placement, attend to baby’s needs and allay the parents’ fears, creating a calm atmosphere for the baby.
179. The parents had a discharge letter containing relevant information including contact details for the hospital, along with advice as completed by the discharging paediatrician. This, combined with the placement information provided by the commissioning team, was considered sufficient to justify the decision to allow the family to stay at the RFC.
180. Ms Jackson set out that the Respondent have made assumptions, for example, that a child was injured on a hot radiator. However, there was no evidence of that.
181. Ms Jackson stated that Ms Maddison did not appropriately intervene in a safeguarding matter or follow the Respondent’s own strict reporting procedures regarding safeguarding concerns, she also did not appropriately inform staff of her observation of an incident when a

resident parent 'roughly handled' her child or record it in Appellant's logs.

182. There was concern that the Respondent added Regulation 7 which was not a feature in the Notice of Decision. This was seen as another opportunistic move to try and personally discredit Ms Jackson.
183. Ms Jackson denied the lack of attachment details on the reports. In her view the Respondent banded this word around without appearing to have much knowledge other than an odd theoretical quote and very subjective personal views. Attachment is also specifically assessed in under the domains of the child's developmental needs: emotional warmth, stimulation etc. The Appellant was running the Incredible Babies' programme which is an attachment based parenting programme.
184. In relation to Regulation 25 reports it served no useful purposes to provide them after the November Appeal Hearing and after considerable concerns regarding the Respondent had been identified by the Appellant. There was no faith in the current inspection team and therefore providing new reports which would not say anything of substance though meeting the technicality of the regulation, was meaningless. Since December 2017 no families have been in placement so no reports have been produced. Information of discussions at management meetings was provided.
185. Ms Jackson stated that a lot of emphasis was placed on the tick being in the wrong place. The context of this document was not considered fully. It is acknowledged that on the weekly update form dated 27th Oct, a tick was out of alignment. This minor administrative error was unhelpful, but the Appellant strongly refutes that it is evidence of an unclear assessment. Action was taken to ensure that this did not happen again as lines added to the grid; a simple error and simple solution.
186. Ms Jackson set out the services of Dialogue Limited were commissioned in September 2017. This was clear evidence that the organisation was doing everything possible to respond to the Respondents criticism.
187. Ms Jackson made reference to the document entitled "Business Plan 2019". This set out what action the Appellant would take to reopen. It included recruitment of staff, updating of IT, governance and appointment of Ms Jackson as the Registered Individual.
188. We heard from Ms Christine Freestone. Ms Freestone confirmed that she commenced working with Dialogue as an Associate in January 2016. She met the Ms Jackson on 14 September 2017. At this meeting, the role of the Critical Friend was discussed in the commissioning of Dialogue to provide an independent view of the progress the organisation was making in correcting to shortfalls

identified by Respondent. Ms Freestone confirmed that various reports were provided starting from 22 September until 8 December 2017. These reports represented an independent view which tracks progress otherwise made by the organisation.

189. The role of the provision was not to act as the Regulator but to provide advice and review evidence towards meeting the standards where there were deficiencies identified by the Respondent, the Appellant, Local Authorities and Dialogue. Ms Freestone noted that the Appellant offered evidence of practice/paperwork/narrative in support of their progress. The reports prepared by Dialogue noted that on some occasions practice and documentation could not be tested because of the reduced number of placements at the centre and the requirement by the Respondent to take no further placements.
190. She confirmed that she was not a social worker. Her audits were not a replacement for Regulation 25 requirements. She stated this was "absolutely" not the case. She confirmed that she was engaged at the point of the Notice of Proposal. She described how she dealt with organisations who were going through a turbulent period. She would use the standards as set out in the Regulations and carry out an audit of the evidence she saw. She would also try and to triangulate evidence as part of her audit. Ms Freestone described how the Appellant had a plan. In her view of such cases, an organisation would look and see where it was perceived to be and also where the Regulator perceived it to be. Her first report was produced in September 2017.
191. In her experience, organisations in situations like this went through three stages. The first stage was "shock". This was a confused stage. In her view, this is where the Appellant was when she joined the Appellant in September 2017. Her job was to calm them down and listen to them. Ms Jackson was at this stage at the time that Ms Christine joined the organisation. She confirmed that Ms Jackson had read all the inspection report at this stage and seemed to be focused.
192. The second stage was the proactive stage. This is when organisations move to complete an action plan. As part of this stage, Ms Freestone had looked at the organisation's risk and RAG rating. She observed that the risk management worked well.
193. The final stage was the "staysis" stage. This is where the organisation could not implement any change as it was restricted from taking families. The Appellant had adopted a very positive way of looking at issues but it was impossible to test new processes as there were no clients present. Ms Freestone confirmed that she did see some learning and some improvement in the risk assessment.
194. Ms Freestone set out in that in her view, it would take a minimum of one year for the culture to be tested. Staff have to be able to practice and test the processes in order to ensure that the Appellant got the result it

wished. The changes depended on the profile of staff and on what could be influenced and achieved.

195. Ms Freestone confirmed that she was not charged with reviewing the assessments. This is because she was not a social worker. Whilst she could ascertain whether or not reports complied with what the letter of instruction required, she could not look at it from the point of view of a social worker.
196. Ms Freestone accepted when she arrived there were concerns about the Appellant. There were concerns around safeguarding and issues around consultation with parents and reporting structures. She concluded that in order for the organisation to move forward, it needed a business plan, staff recruitment and, considering the number of families it was going to begin with, have structures in place which ensured clarity, check the plan and supervise it. It was also important to check the understanding of the process and if it was operating effectively and to monitor and implement progress. Any new staff would need to be aligned with the organisations vision. The Appellant would need to ensure that practices tested were regularly.
197. In her view any changes needed to be embedded. This could be monitored through quality monitoring through external audits, regulatory audits and local authority audits. The organisation needed to be a learning organisation. In her view, it should take findings, reflects on them and embed any changes. Furthermore, there had to be root cause analysis. For example, why it happened and reflecting on everyone's role.
198. In Ms Freestone's opinion, the inspector's concerns were justified. The evidence at the Appellant's RFC was not organised and not immediately accessible. The Appellant should have had a server/ folder which provided inspectors with the information they required in order to triangulate evidence from different places. In her view, she could see where the Regulators were coming from.
199. Her positives about the Appellant included that its staff were passionate and welcoming of new ideas. For example, it changed the RAG rating and were committed to the organisation changing.
200. The negatives were that she found were that the organisation was "lost". It was in shock and denial. There was a lot of confusion and staff were not clear. She confirmed that she had had "frank exchanges", "honest exchanges" and "professional differences" with Ms Jackson. She did not consider this to be a bad thing.
201. Ms Dunn set out that she had been employed by the Appellant between May 2008 until December 2017 as a Resource Worker and as part of the assessment team. She spoke about parents being treated in a respectful and non-judgemental with staff building up their trust to

ensure that they got a fair, unbiased assessment. Ms Dunn described one incident on 20 June 2017 relating to Ms Maddison. She had been asked about child CW being there for so long and whether not she got upset about that. She had replied that it was up to the court to decide. Ms Dunn set out that Ms Maddison had not spoken to her about any incident regarding rough handling nor indicated that she wanted them to report it.

202. Ms Louise Philips set out that she was the Human Resource Manager. She described the inspection on 23 June 2017 and of being asked by the Ofsted inspectors for a variety of documents. She set out that she had taken a supervision folder to them. In addition to the one-to-one supervisions there were also details of staff attendance at the monthly staff meetings. These meetings partly acted as a group supervision, peer support and reflection on practice.
203. Ms Philips described how supervisions were split between social work supervision for social workers undertaken by a social worker and standard supervision undertaken by her and Ms Jackson. She set out that the staff who had standard supervisions, a question was always asked to ascertain if they require any further supervision from a social worker. Additionally, staff were made aware that they could request supervision at any time which was always accommodated. Furthermore, the daily handover also provided an opportunity for staff concerns to be reported and reassurance and support to be given. A written account of these arrangements was submitted with the response to the first monitoring visit.
204. Ms Phillips also accepted that some of the Respondent's concerns regarding agency staff were accepted as being valid. However, there were unusual circumstances such as the sickness levels at the time. Steps were taken to address the issues raised by the Respondent and were initially met with resistance from the agencies. By September 2017, agreement had been reached with the agencies on the future procedure should agency staff be used, but this had not been implemented given the decline in the number of families and there was no longer a need for agency staff.
205. Ms Phillips also described the monitoring visit which took place on 20 February 2018 by the inspectors. She described that this has been a completely different experience. The new inspectors were considerate, listened, asked for paperwork/evidence and enabled it to be explained. The inspectors also spoke about working with the Appellant should business continue. Ms Philip's felt this was a different approach to the inspections.
206. Ms Sinclair set out that she worked at the setting until January 2017. She had opened the door to the Respondent's inspectors, checked their ID, explained the fire procedure, assembly point and informed them that a drill was not planned. She set out that Ms Maddison had asked

whether the Registered Manager and Registered Individual were at Glastonbury. Whilst she acknowledged that there was nothing inappropriate about inspectors asking about the whereabouts of the Registered Individual and Registered Manager, she found it “*very strange that they had asked of Julie’s whereabouts and Glastonbury*”.

The Tribunal’s conclusions with reasons

207. We took into account all the evidence that was included in the hearing bundle, presented at the hearing and took into account the lengthy written closing submissions.
208. We wish to place on record our thanks to both Ms de Coverley and Mr Pojur and all the witnesses for their assistance with the hearing.
209. We acknowledge that this hearing took longer to conclude than had been anticipated at the outset. This was due to a number of factors including a large volume of late evidence (2 lever arch bundles) submitted by the Appellant on the first day listed for an oral hearing (1 May 2018). We considered it right and proper for the Respondent to have the opportunity to consider this evidence and make representations. The parties had also informed the Tribunal at the first hearing that they had entered into negotiations which may lead to resolution of the appeal without a contested hearing. We allowed a period of time for such discussions and it was explained to us that whilst lengthy discussions took place with regards to a resolution ultimately, no such agreement was reached.
210. We considered at the hearing in July 2018 that it would be helpful that the parties prepare a second, concise and unified Scott Schedule. The initial Scott Schedule did not identify the issues in dispute clearly and we considered that the case, involving multiple allegations and substantial documentary evidence would benefit from such a document in order to ensure that the contested issues were clear. It would have been helpful if the Scott Schedule (normally prepared by the Respondent), set out a list of the allegations/issues relied upon and each allegation included a reference to where the evidence can be found in the bundle. Equally, the Appellant should have responded to each allegation/issue on the document, including setting out whether the allegation/issue was accepted or not and a reference to where any evidence in response could be found in the bundle. We are grateful to Mr Pojur and Ms de Coverley for preparing a document which at the very least set out the issues in dispute.
211. The hearing in July 2018 was adjourned due to insufficient time to hear all the evidence. The parties agreed that initial time estimate (proposed by the parties after the hearing in April 2018) was not sufficient and more time was required. Furthermore, due to the limited availability of both the Appellant’s and Respondent’s Counsel and the Tribunal Panel, the earliest date that all the parties could reconvene for the part heard

hearing was 22 January 2019. We wish to make it clear that this is not a criticism of any of the parties or their representatives, it simply represented the position with regards to the earliest availability, despite the best efforts of all concerned.

212. Following the conclusion of the oral evidence, we made directions with regards to closing written submissions. The Respondent made an application to adduce additional evidence about its complaints procedure in response to the Appellant's evidence regarding a complaint made by another organisation, Tumblewood. This application was made at the same time as its written submissions were sent to the Tribunal.
213. The Appellant made a further application (dated 13th March 2019) over 4 weeks after the oral evidence had been concluded and almost 2 weeks after its written submissions had been filed. The application was *"leave to state by way of clarification. The Appellant holds concerns regarding a discrepancy in Ofsted submissions."*
214. We carefully considered both applications and the attached documents. We noted that both applications were made after the oral evidence had been concluded. We acknowledge that the Respondent's application was made in response to an application made on the last day of the hearing by the Appellant to admit evidence relating to the other provider. We could understand why it was made, as although the Respondent was made aware that an application may be forthcoming, the exact details were not provided until the final day (7 February 2019). In any event, we concluded that we would refuse the application on the basis that the oral evidence had concluded and it would be unfair to permit either side to rely on documents that had not been seen by the other side and which the other side had not had an opportunity to comment on.
215. We also considered the application made by the Appellant. We reminded ourselves that the Appellant was legally represented throughout the proceedings and written submissions were prepared by the Appellant's Counsel. There was no explanation provided in the application as to why the clarification or the Appellant's concerns were not submitted as part of the written submissions or referred to earlier in the proceedings. We had made significant allowances for the Appellant and the late evidence that we were presented with during the various hearings. However, we took the view that it was only right and fair that we refused the application on the basis that it was submitted after the oral evidence had been concluded and almost 3 weeks after the written submissions. We wish to make it clear that even if we had been minded to allow both the Respondent and the Appellant's applications, it would not have changed our final decision set out below.
216. We acknowledge that Ms Jackson was not feeling well on some of the days whilst giving evidence. Mr Pojur informed us on 24 February 2019

that Ms Jackson would not be ready to give her evidence on that date as she was not well. This was despite the parties being ahead on their agreed witness schedule. We agreed to adjourn on 24 February 2019 in recognition of this and Ms Jackson's evidence started on 25 January 2019. Ms Jackson informed the Tribunal on 25 January 2019 that she was well enough to provide her evidence to the Tribunal.

217. At the reconvened hearing on 5 February 2019, Mr Pojur informed the Tribunal that Ms Jackson had been under the care of the doctor in the intervening period (between 25 January and 4 February 2019). We asked Ms Jackson if she was well enough to continue to give evidence and she informed us that she was. Ms Jackson was provided with a break in the morning and a break in the afternoon in order to ensure that she was comfortable in giving her evidence. The Tribunal panel also asked Ms Jackson at various points in the hearing whether she was well enough to continue. She informed the Tribunal that "*I will continue and I can assure you that if I can't continue I will stop*". We were content to proceed on the basis of this assurance. We reminded ourselves that Ms Jackson was familiar with giving evidence as a witness, albeit in family proceedings, and we were satisfied, on the basis of Ms Jackson's assurances, that if there was an issue which affected her ability to give evidence, then she would bring it to our attention.
218. Ms Jackson's evidence on 5 February 2019 ended at around 4:40 PM as she felt unwell. On 6 February 2019, Ms Jackson indicated that she wanted to proceed with the hearing and was well enough to give evidence. Once again, we were content to proceed on the basis of her assurances.
219. We made particular allowances for Ms Jackson at the hearing. During the course of the of Ms Jackson's oral evidence, it became apparent that she was using notes which were handwritten. Mr Pojur explained that these were simply an aide memoire. There were references to her own statement and to refresh her memory. Ms de Coverley raised an objection. In her view, if Ms Jackson were to rely on handwritten notes then the Respondent expected to see a copy. We heard submissions from both Mr Pojur and Ms de Coverley and concluded that if Ms Jackson wanted to rely on the document then she should disclose it. Ms Jackson confirmed that she was more than willing to disclose a copy of her notes. A copy was provided to the Tribunal Panel and to the Respondent.
220. Ms Jackson informed the Tribunal on 5 February 2019 that she had prepared an additional statement which was sealed in an envelope that she wanted to hand to the Tribunal at the conclusion of her oral evidence. This statement contained her thoughts and feelings that she wanted to bring to the attention of the Tribunal. Mr Pojur confirmed that he had not provided a copy of the document and did not know what it contained. Ms Jackson informed the Tribunal that she did not want a copy to be given to Respondent and to the Tribunal until she had read

the statement out loud and she did not want to answer any questions on it. We gave Ms Jackson the opportunity to reflect overnight on what she wanted to do, explaining to her the importance of maintaining fairness between the parties.

221. On 6 February 2019, Ms Jackson confirmed that she would be relying on the written statement. However, she reiterated her position in that she did not wish to provide a copy of the statement to the Respondent or the Tribunal until after she had read it and did not want to be questioned on it. Mr Pojur submitted on her behalf that it was simply an aide memoire. Ms de Coverley confirmed that whilst the Respondent, (very fairly in our view), did not object to the document, she reserved the right for the Respondent to ask questions on it. Ms de Coverley's difficulty was that she had not seen the document referred to.
222. We concluded that if Ms Jackson sought to rely on this additional statement then a copy needed to be provided to the Tribunal and to the Respondent (as well as her own Counsel, Mr Pojur) in advance of Ms Jackson reading out the statement so that questions could be asked about it. We allowed Ms Jackson to make a decision as to whether not she wanted to rely on it. Ms Jackson decided that she would rely on it and would disclose it. We concluded that Ms Jackson would be permitted to read out a statement and, if the parties or the Tribunal, had any questions then they could ask them at the end. In any event, after Ms Jackson had read her statement, Ms de Coverley did not have any questions for her.
223. We acknowledged that the Appellant's case was that the Inspectors information was inaccurate, exaggerated and untruthful. However, we did not find that the evidence supported the assertions made by the Appellant. We concluded, based on the evidence that we read and heard, that all the Respondent's witnesses gave clear, consistent, credible, measured and reliable evidence. Their conclusions were well supported by the evidence, such as the contemporaneous notes of their inspections/monitoring visits.
224. We found that all the Respondents witnesses were all very careful in their evidence. For example, the Respondent's witnesses were careful to defer to the appropriate inspector where necessary during cross examination. The Inspectors were quick to recognise any improvements which had been made. For example, Mr Lowe, Ms Maddison and Ms Canto all acknowledged there had been some improvement in the documentation (such as the introduction of a new RAG rates risk assessment). We were not presented with persuasive evidence that there was any "*closing ranks*", or any other inappropriate conduct. The Appellant was provided every opportunity to provide evidence of compliance and capacity improve at inspections and the Appellant's own witnesses, Ms Freestone and Ms Sinclair accepted that information was not always easy to locate.

225. The Appellant's main witness, Ms Julie Jackson raised concerns about Ms Maddison but described the other inspectors in more positive terms although she did say that the Appellant had no confidence in the South West Team. For example, Ms Jackson described Ms Canto as being "*pleasant to deal with*" and had provided good advice about escalating matters within a Local Authority. Another witness, Ms Dunn described the inspectors (which included Mr Lowe) on 20 February 2018 in positive term describing them as being considerate and listening.
226. On the evidence we heard, it appeared that Ms Jackson was mistaken in her belief that there was a personality clash between her and Ms Maddison. The letter from Devon County Council (dated 10 April 2017) which was cited as evidence by the Appellant of having received a written apology from Devon County Council due to information which came from Ms Maddison was not borne out on closer scrutiny of the letter itself. There is no reference in the letter to Ms Madison nor to the Respondent. We accepted Ms Maddison's evidence that she had attended the meeting at the invitation of Devon County Council and had explained to the meeting that she had closed down the case she had relating to Ms Jackson's son, Mr Reid. On Ms Maddison's evidence, her update supported Ms Jackson.
227. We found that the Respondent made great effort to try and assist the Appellant. For example, Ms Maddison was involved in the decision to extend the June inspection so that the Appellant would have an extra day to provide the information. Ms Bailey also explained that it would be unusual to serve a further Compliance Notice but that Mr Lowe had wanted to give the Appellant every opportunity to comply and therefore a second Compliance Notice was issued on 4 August 2019. A further example of the Respondents reasonable approach to this matter which we observed was that none of the inspection reports from 2017 had been published by the Respondent at the time of these hearings. We should say that we have no jurisdiction to prevent those reports being published or otherwise and the Respondent had taken this action on its own initiative.
228. We acknowledge that the Responsible Individual and the Registered Manager (Mr I Jackson and Mrs J Jackson) have built the setting over the last 12 to 13 years. We had no reason to doubt Ms Jackson's stated passion for this work and the work that has been put into establishing the setting which included Mr and Ms Jackson moving out of the setting which was their home at the time.
229. We had a number of written statements and heard oral evidence from Ms Jackson over a period of 2 ½ days. We found Ms Jackson's evidence was not credible. We acknowledge that it is not easy giving evidence at a hearing, however, in our view, Ms Jackson did not specifically answer a large number of questions which were put to her under cross examination. Ms Jackson made it clear that she would

provide context as part of answering any questions in cross examination but in many parts of her evidence, context was provided for issues unrelated to the the question asked.

230. Ms Jackson was reminded periodically during her oral evidence of the need to answer the question asked but that she could, if she wished, provide any context in relation to responding to the question asked. However, Ms Jackson proceeded to provide lengthy responses which often did not relate to the question asked. We found her responses to be unfocused and evasive and many questions which were asked were treated as an invitation to answer a question that Ms Jackson wanted to answer or make a submission on another point. In our view, it would have been far more helpful, as Ms Jackson was regularly reminded during her oral evidence, for her to answer the question that was asked by Ms de Coverley and then provide context for her answer to the question asked.
231. We found the evidence of Ms Dunn, Ms Phillips, Ms Sinclair to be helpful insofar as the limited issues that it addressed. We found the evidence of Ms Freestone to be careful, measured and reflective of her limited involvement with the Appellant over the period from September to December 2017.
232. We also read all the witness statement submitted by the Appellant relating to witnesses who were not required to give oral evidence. Overall, where there was a conflict in the evidence we preferred the evidence of the Respondent's witnesses for the reasons we have set out above, including that their evidence was supported by their contemporaneous notes and other documentary evidence.
233. We were referred to complaints submitted by another provider, Tumblewood. As we understood the position, it is not, and has never been, disputed by the Respondent that Tumblewood have raised concerns with the Respondent following an adverse inspection at the end of 2017. We rejected the allegations made by the Appellant that we were misled by the Respondent's witnesses in this regard during their evidence. We did not find this to be the case. We found the Respondent's witnesses were clear and consistent in this regard. In our view, the weight that can be placed on the evidence relating to a completely different setting was minimal. We did not have a statement from that provider and therefore did not have the full picture. We did not find that anything we read and heard regarding Tumblewood would undermine the inspection process and conclusions drawn about the Appellant, which we judged on the evidence before us.
234. We note that Section 18 of the Act confers upon the Registered Person the right to make written representations in respect of the proposed action to be considered before the decision is made final. There is no requirement, by law, for the Respondent to allow oral submissions. In

this case the Appellant had submitted a detailed written response and was sent a link containing the relevant information.

235. In any event, the Tribunal makes its decision on the basis of all the evidence available to it at the date of the hearing and is not restricted to matters available to the Respondent when the cancellation decision was taken.

236. We acknowledge that until June 2017, there had not been any issues which had led to any enforcement action. The last inspection on 23 January 2014, resulted in an overall rating of "Good".

237. However, having considered all the evidence, we concluded that the requirements of the Care Standards Act 2000 were satisfied. We concluded that the RFC is being or has at any time been carried on otherwise than in accordance with the relevant requirements. We also concluded that Compliance Notices relating to the establishment or agency have been served and the person on whom the notice was served has failed to take the steps specified in that notice within the period specified. Our reasons for doing so are set out below.

238. We understood the Appellant's case, as conveyed during the hearing by Mr Pojur, was on the basis that "*no admissions are made in terms of any breaches*". This was also set out in the Appellant's skeleton argument. This later evolved to a statement that the Appellant "*has not at any time carried out anything that would justify cancellation*". We proceeded on the basis that no admissions were made.

239. However, the position at the hearing contradicted the position as set out in the response to the Notice of Proposal drafted by Mr and Mrs Jackson dated 10 October 2017 (which we were told by Ms Jackson included input from the staff) which states that;

"there was a clear recognition that we needed to make significant improvements to paperwork and practice across the board in order to demonstrate our compliance with multiple regulations".

240. Furthermore, the response went on to say;

Serendipity management and staff team are fully committed to making the necessary changes and improvements practice (sic) and we believe that this commitment is reflected in the positive changes which have been made since August.

"...it appreciated that the positive changes need to be embedded into serendipity's practice..."

"... 2017 has been a difficult year for serendipity and OFSTED's concerns regarding practice across the board are fully accepted.

241. Ms Jackson's statement dated 8 March 2018 also acknowledged that

“..PH (Pippa Hector) had not understood properly considered the amended OFSTED inspection guidelines for inspection. She had considered that we were up-to-date with our practise and had informed me that we were ready for an inspection. I acknowledge that I needed to have verified findings for myself but did not. I trusted her judgement”

242. Ms Jackson also accepted that the

“referral document filled in by the local authority social workers and some of our written information was not up to regulation standards”.

243. There were further admissions. The incident discovered at the second inspection in August 2017 which concerned a baby with an unexplained bruise. Ms Jackson’s statement states that;

“safeguarding procedures were not followed correctly. I acknowledge that this was a serious safeguarding breach and not acceptable and in response I arranged an external company to deliver safeguarding training”.

244. Ms Jackson set out that she had initially sat down with the team and drafted the response to the Notice of Proposal and that was how the team felt at the time. However, since then she had looked into it and changed her approach. We were not clear and nor did Ms Jackson explain on what basis she had looked into it and what evidence demonstrated that the previously accepted breaches were no longer accepted as breaches. Dialogue began working with the Appellant in early September 2017. We acknowledge what Ms Jackson says with regards to the inspector’s evidence, however, the Appellant’s own witness, Ms Freestone accepted when she arrived there were concerns about the Appellant including justified concerns around safeguarding and that she could see where the inspectors were coming from.

245. We found that Regulation 23 and Regulation 25 of the 2002 Regulations were breached along with the associated NMS. The Appellant has failed to comply with Regulation 25, which, as Ms Freestone accepted, would have helped demonstrate capacity to change. We agreed with Ms Freestone’s analysis that the work of Dialogue was not a replacement for the Regulation 25 process and in our view, neither was the information of discussions at management meetings. We were concerned that the Appellant did not appear to appreciate that the Regulation 25 report should be completed even if there were no families present and despite her perceived concerns about the inspectors. Whilst Ms Jackson may well feel that there was “no point” in providing the Regulation 25 reports on the basis that there were no families in residence, this approach was with complete disregard for what was required. This failure to report means that the Respondent was unable to ascertain whether there have been improvements implemented.

246. We concluded that the Tribunal cannot be confident that children in the setting have been protected from harm. We concluded that Regulation

10 and 12 of the 2002 Regulation and related NMS have been continuously breached. This includes NMS 5.8 which sets out that staff need to be alert to any signs or symptoms that might indicate that a child is at risk of harm.

247. We found that a number of incidents had been minimised by the Appellant, despite being child safety concerns. We found that the incident involving a bruise on a baby (in August 2017) was a safeguarding breach. In fairness, Ms Jackson, in her statement dated 8 March 2019 recognised that this was a “*serious safeguarding breach*” and “*not acceptable*”. We were concerned about the failure of the staff and managers to follow the child protection procedures. The injury on the baby’s leg was noted in the logs for 18 August 2017 by staff but was not referred to senior staff or the placing authority. The managers became aware of the injury on 21 August 2017 but failed to follow their own child protection policies and procedures. It was left to the placing authority to refer the issue to the Local Authority Designated Safeguarding Officer.
248. We were concerned that two inspectors had to ask a member of the Appellant’s staff, Ms Pippa Hector (Social Worker) twice to cease from investigating the incident. It was not clear as to how the injury had been caused and by whom and therefore this investigation should not have been undertaken by another employee of the service without independent scrutiny from the designated officer of the Local Authority. We agreed with the Respondent’s assertion that this was a fundamental principle of good safeguarding practice and for the setting entrusted to safeguard children at very real risk of harm to get this wrong was deeply concerning.
249. We found that staff had failed to intervene and safeguard a baby, when a parent placed the baby on the changing mat on the floor too close to a radiator in the bathroom. The Appellant’s staff failed to observe that the baby was too close to the radiator. The baby wriggled and was left with a red mark after contact with the radiator (as recorded in the Appellant’s own Body Injury Chart dated 26 September 2017). We acknowledged that the radiator was not hot and this was something that was conceded by the Respondent and amended through its factual inaccuracy process. However, we shared Ms Maddison’s view that the issue was about the lack of intervention when a baby came into contact with the radiator. Furthermore, the Appellant did not appear to learn any lessons from this incident as there was no debrief of the staff by managers regarding what could have been done differently and what they learned from the incident to ensure that the incident was not repeated.
250. We also concluded that staff did not promptly intervene to ensure the safety of a baby in relation to an incident on 5 May 2017. This relates to a parent against whom were known concerns about the parents safe handling of their baby. The Appellant’s staff did not intervene despite observing the parent and baby on CCTV and despite recording in the

log *“it is clear that mother heard the baby and had not responded to her distress”*.

251. We concluded that at inspection in June 2017, that staff failed to intervene whilst the baby was being handled roughly. It was concerning that 6 months had passed since placement and that the Appellant’s staff had allowed it to go on for so long without intervention. This prompted the inspector, Ms Maddison to call the LA. We acknowledge that the Appellant’s witnesses sought to downplay Ms Maddison informing staff (Ms Dunn and Ms Bisgrove) of what she had observed. However, Ms Maddison’s account is supported through her contemporaneous notes as attached to her statement.

252. We found that the Appellant had admitted a critically ill baby (“Baby S”) with a heart condition without its paperwork in place. Ms Jackson could not explain why the paperwork was not there. We acknowledge Ms Jackson’s position that she could not turn away a critically ill baby with a heart condition after it had undergone a lengthy journey. However, the issue was why the paperwork was not in place and why checks were not made repeatedly to obtain the paperwork prior to agreeing to offer the child a placement. In our view, it was concerning that the Appellant (whose staff included agency staff at the time) was monitoring families without evidence that they had the required skills to respond to the very specific and critical needs of this child. It was also not clear why the Appellant did not have the Emergency Duty Team (EDT) details, or contact details of the hospital for Baby S. It was also not clear why the Appellant did not contact local hospitals to discuss an overnight stay. The medical paperwork relating to Baby S was not complete even though a significant passage of time had passed by the time of the hearing. We were not presented with any evidence that medical checklist/risk assessments were carried out on the evidence provided. In our view, the paperwork should have been obtained prior to the admission. We were not persuaded that lessons had been learned in relation to Baby S. Ms Jackson made it clear that if the situation happened again, she would accept the baby, even without its paperwork in place.

253. Overall, we also found that there was confusion as to the point at which a safeguarding incident would be reported. The monthly report from Dialogue (September 19-23, 2017) made reference to a consultancy visit on 20 September 2017 where a member of staff reported a quarter of an inch scratch to a resident infant. The report made it clear:

“that the centre MUST (their emphasis) ensure that any mark or cause for concern however small or minor must be reported to the appropriate authority and where necessary to the regulator within the appropriate timescales. This should be the immediate reaction in order to ensure robust safeguarding practices and processes”.

254. However, in her oral evidence, Ms Jackson focused on the “quarter inch scratch” not being something she would normally report. Ms Jackson also made unsupported assertions as to whether or not there were sufficient resources available at the EDT to deal with such calls. This confusion around safeguarding issues was further evidenced by the review log (page F230) which identified 3 incidents which rated the management response as “requiring improvement”, although we accept that one of them was identified as a safeguarding concern whilst the other two were classed as being a low risk.
255. Whilst we acknowledge that there had been some improvement as evidenced in the Dialogue report dated 4 December 2017, nevertheless, given that the centre had not been operating since December 2017, we could not evaluate whether or not these changes/improvements had become embedded.
256. We were also concerned with the overall record-keeping of the Appellant. We heard significant evidence about whether or not a tick was in the right place and the context for a particular word and it being underlined (i.e. breathily). However, what this highlighted was that the record-keeping at the setting was unsatisfactory and unclear.
257. We reminded ourselves that the Appellant provides a facility where families are sent for close observation and assessment of their parenting abilities over a period of time, usually in the context of care proceedings. The children who are cared for at the settings are particularly vulnerable and already seen by the Local Authority and the Family Court as being at risk of significant harm in their parent’s care. The purpose of ordering an assessment is to give the parents what is usually a final opportunity to demonstrate whether they can safely meet the care needs of the child whilst being monitored and closely observed with the expectation that the RFC will intervene and safeguard the child if necessary. Records need to be clear and accurate in all circumstances including where service users are vulnerable.
258. A further example of inaccurate record related to reports. We were informed by Ms Jackson that the Updating Report on the 12 week Residential Family Assessment dated 20 September 2017 was completed by a Social Worker with input from Ms Jackson. However, the report itself sets out that it is prepared by Ms Jackson, is the report of Ms Jackson and is signed by Ms Jackson. There is no mention of any other input in the copy we were provided. As Ms Jackson herself accepts, she is not a social worker and, therefore, in our view she should not have signed this report as it creates a misleading impression.
259. We also concluded that the Appellant was served with Compliance Notices on the 6 July 2017 and 4 August 2017. These were addressed to Ms J Jackson. We concluded that the Appellant failed to take the steps specified in that notice within the period specified. Those Compliance Notices clearly set out what needed to be done and by

when and the Appellant has failed to take the action specified which including dealing with the issues identified around managing risk. We reminded ourselves that failure to comply with a Compliance Notice is also relied upon as a second ground for cancellation of registration.

260. We concluded that our findings as set out above around safeguarding alone were so serious that they led us to conclude that the RFC is being or has at any time been carried on otherwise than in accordance with the relevant requirements.
261. On the basis of the seriousness of our findings around the safeguarding issues and non compliance with the Compliance Notices, we therefore did not go on to deal with the other issues as set out in the Scott Schedule in great detail. However, had we gone on to deal with those issues, we would have found that there were unclear rules and boundaries (particularly around staff failing to intervene when a parent woke their baby up to bathe it at 9pm), there was a failure to deal with the issue of attachments in assessments, particularly at the interim stage, there was a drift and delay (including relating to AL/BD), failure to demonstrate proper understanding of the effect of drift and delay on a baby and a specific delay in KA's assessment. We would have also found that letters of instruction were frequently not in place at the setting and that failure to have one in place would impact on the placement going forward. The generic document produced by the Appellant was insufficient in our view as it did not meet the requirement for individualisation of plans as set out in the NMS.
262. Furthermore, as the setting is currently not operating, there are limited staff, some operating on a sessional basis. Regulation 15 is therefore also currently in breach.
263. We found that the Registered Manager has not exercised effective leadership so that the centre is organised, managed and staffed in a manner that delivers the best possible outcome for parents and children. We found that as at the hearing there was a lack of insight on the part of the Registered Manager. Whatever insight there had been at the time of the Notice of Proposal and in March 2018 had disappeared by the time of the hearing. Ms Jackson correctly accepted in cross examination that it was her responsibility to be aware of the law and to comply with it. We understood that the Appellant may have delegated the tasks to others such as Ms Pippa Hector, Ms Sally Apps and Dialogue but the overall responsibility and accountability remained with her. We were made aware that the Registered Manager, Ms Jackson's intention was that she saw herself in any future reopening of the RFC as taking the position of the Responsible Individual. However, given our findings above we could not be confident in her ability to carry out the full obligations of the role of the Registered Manager or Responsible individual. We did not find that reorganising those who manage the setting would solve the fundamental issues it has.

264. Our conclusions were also based on the evidence of Ms Freestone who supported what the Respondent's witnesses set out. In particular, Ms Freestone set out that when she arrived in September 2017, the organisation was in "shock and denial". In our view, that is where the Appellant appeared to be at the time of the hearing. There is nothing wrong with challenging the conclusions reached by the Regulator, but there has to be persuasive evidence to demonstrate that. In this case there was not. As Ms Freestone stated, an organisation should take the findings, reflect on them and embed any changes. There had been no root cause analysis as Ms Freestone suggested. Whilst we acknowledge there is a Notice of Restriction in place, nevertheless, it is clear that the significant failings were attribute to staff not just procedures. We agreed with Mr Lowe's and Ms Freestone's conclusions that whatever processes were revised, these cannot be fully tested at this point and we were not presented with evidence that the culture in practice had changed sufficiently to meet all compliance and practice requirements.
265. We considered the plan that had been put forward. The plan lacked any detail. This was a generic plan and for example included in oral evidence that "external governance" would be put in place, with no clarity as to what this would entail. Furthermore, the business plan lacked detail and involved Ms Jackson being appointed as the Registered Individual.
266. We considered whether cancellation was proportionate and necessary taking into account all the circumstances of this case. We concluded that it was. We acknowledge the Appellant's previous inspection ratings, Mr and Ms Jackson's passion for this work, the relevant factors in this case including the impact on key stakeholders (including any staff and service users) as well as the history of the Appellant.
267. We reminded ourselves that those resident at an RFC, given the nature of their needs, are particularly vulnerable, requiring continuous support, observation and assessment. Each resident parent requires a full and fair assessment of their parenting skills and capacity, and should be given individualised support, in line with their abilities, needs and background. Each resident child should feel protected and safe, and benefit from effective parenting. There is no doubt that the Appellant has been provided with ample opportunity to meet the requirements and ensure that the settings met the relevant regulations and NMS. This included a number of inspections and monitoring visits. The Appellant had received feedback as to what needed to be done and has failed to do so. Furthermore, and in circumstances described as "unusual", the Appellant has been served with two Compliance Notices and has not complied with them despite the risk of prosecution. The inspections reveal a number of regulatory failings which were significant and sustained.

268. Whilst we acknowledge that there has been a Notice of Restriction (renewed periodically) in place, we heard evidence from Ms Bailey that any improvements could have been carried out and notified through the regulator through the Regulation 25 process. Furthermore, the Appellant's unwillingness to accept any of the breaches identified is important as the Appellant has no capacity to accept or reflect or improve. We consider that, given the circumstances of this case and the nature of our findings cancellation is both necessary and proportionate.
269. We therefore confirm that the Respondent's decision dated 23 November 2017 to cancel the Appellant's registration is confirmed.

Decision

270. The decision to cancel the Appellant's registration is confirmed and the appeal is dismissed.

Mr H Khan (Judge)
Ms J Cross (Specialist Member)
Mr J Churchill (Specialist Member)

First-tier Tribunal (Health Education and Social Care)

Date Issued: 26 March 2019