

Care Standards

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

[2018] 3583.EA-MoU

Heard on 28th & 29th January 2019 at the Royal Courts of Justice, London

BEFORE

Tribunal Judge Timothy Thorne
Specialist Member - Michael Flynn
Specialist Member – Wendy Stafford

BETWEEN:-

BAYTREE COMMUNITY CARE (LONDON) LTD

APPELLANT

-v-

THE CARE QUALITY COMMISSION

RESPONDENT

DECISION

The Appeal

1. Baytree Community Care (London) Ltd, the Appellant (A) appeals to the Tribunal against the decision of the Care Quality Commission (CQC) contained in the Notice of Decision issued on 10th December 2018 to vary the Appellant's registration so that the regulated activity of "accommodation for persons who require nursing or personal care" may not be carried out at Holmwood, 11 Harvey Lane, Norwich, NR7 0BW, "the Home".

Factual Background

2. A is the Registered Provider for Holmwood. Mr Mistry is a Director and Nominated Individual, and has been registered and operating services since 1998. A operates two services: Baytree Lodge and Holmwood. These proceedings are concerned only with Holmwood.
3. The relevant chronology can be summarised as follows:
 - a. 26th November 2018: CQC inspection at Holmwood
 - b. 27th November 2018: CQC issue Letter of Intent to the Provider, seeking a response within 24 hours. A response was provided.
 - c. 30th November 2018: CQC issued an Urgent Notice of Decision ("UNOD"), imposing a number of conditions on the Provider's registration, and requesting a response by 6th December 2018.

- d. 6th December 2018: a response was provided to the 30th November UNOD, and a follow up inspection was conducted at Holmwood by the CQC.
- e. 10th December 2018: CQC formally notified the Provider of their decision under Section 31 of the Health and Social Care Act 2008 to impose conditions on their registration, specifically that the regulated activity of “accommodation for persons who require nursing or personal care” may not be carried out at Holmwood, 11 Harvey Lane, Norwich, NR7 0BW.
- f. 7th January 2019: Notice of Appeal filed.
- g. 14th January 2019: Response to Notice of Appeal.
- h. 17th January 2019: Exchange of evidence

Representation

4. A was represented by Mr Matthew Chidley and the CQC by Ms Rachel Birks.

Restricted Reporting Order

5. 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 users of the service in this case so as to protect their private lives.

Late Evidence

6. The Tribunal was asked to admit additional evidence by the A and the CQC. This consisted of the written responses by A to the draft CQC report, the consequent final report of the inspections by the CQC, reports on the Home from Norfolk County Council concerning 2 inspection carried out on 14 and 23 November 2019 and various template forms produced by A.
7. The panel applied rule 15 of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008 and took into account the overriding objective as set out in rule 2 and admitted the late evidence as it was relevant to the issues in dispute.

The Hearing

8. The panel took into account all the documentary and oral evidence that was presented. The panel first heard oral evidence from **Ms. Gemma Hayes** an Inspector in the Adult Social Care Directorate of the CQC. She adopted her witness statement dated 16 January 2019 and confirmed that she had been responsible for the oversight of Holmwood since March 2018. She was the Lead Inspector on the inspections carried out on 26 November 2018 and 6 December 2018 which led to the Decision being taken.
9. She explained that both inspection were undertaken against the framework of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which set out the expectations on the delivery of regulated activities.

The Inspection carried out on 26 November 2018

10. The witness set out the following concerns found during this inspection by reference to the following regulations:

- a. Regulation 12 – Safe Care and Treatment due to concerns about:
- i. Condition and cleanliness of the care environment and in particular:
 - There were exposed hot pipes and uncovered radiators
 - Window restrictors were not fitted to all windows
 - Service user’s laundry was not kept clean
 - Urine was not being properly cleaned up
 - Personal protective equipment was not worn
 - There was a lack of paper towels in a bathroom
 - There was a toilet seat missing
 - There was no sink in the medicine room
 - The lift was being used for storage
 - There were poor unclean bathrooms, toilets and en-suite facilities
 - Considerable mold and dirt were identified in a bedroom that had recently been used
 - Broken glass was seen to be accessible in a setting where service users have a history of self-harm and changing mental health presentation and where it could also have been used as a weapon.
 - ii. Poor standards of care, in particular:
 - Soiled laundry was piled up
 - Service users were noted to have poor personal hygiene
 - Poor oral hygiene was identified and service users did not have the basic tools to manage their personal hygiene either independently or with assistance
 - iii. There were risks relating to poor fire safety, in particular:
 - There was only one service user with a Personal Emergency Evacuation Plan on 26 November 2018 despite a known risk of arson
 - Fire doors were damaged
 - There were cluttered rooms hindering exit in event of fire
 - Smoking was taking place within the Home and cigarettes were not always safely extinguished
 - Cigarette lighters were being accessed by Service Users as they were not stored securely
 - Risks of barricade were not being mitigated pending the service user being moved to different accommodation
 - Staff did not have keys to access all rooms in the event of an emergency
- b. Regulation 17 – Good Governance due to concerns about:
- There was a lack of quality audits
 - Poor systems for completion of daily records were identified
 - Environmental risk assessments were not thorough
 - There was a lack of organised systems by the management team for the management of information relating to the running of the Home and people living at the service
 - Problems with incident management and follow up were identified

- c. Regulation 18 – Staffing due to concerns about:
- Staff were unable to get assistance in the event of an emergency
 - Female staff members were working in isolation despite known risks including a previous sexual assault by a service user
 - There was insufficient staffing and lack of a dependency rating tool, and when implemented the dependency rating tool was not accurately completed
 - There was the lack of a lone working policy at the inspection on 26 November 2018 and when one was implemented it was inadequate.
 - Staff lacked knowledge of historic risks
 - There were no risk management plans to protect staff
11. She also produced a number of photos taken during the inspections which corroborated her testimony. As a result of these findings, CQC contacted Norfolk Fire & Rescue Service (NFRS) who visited the Home. They informed CQC of 26 points of concern and issued A with an enforcement notice. In addition a safeguarding referral was made to Norfolk County Council (NCC).
12. On 27 November 2018 the witness attended a Management Review Meeting (MRM) and an urgent letter of intent was sent to A notifying them of the serious concerns the CQC had. A responded by letter on 28 November 2019 within the agreed timetable. The CQC were unhappy that A appeared not to be taking the matter seriously as the timescales put forward for dealing with the concerns was too long and there was a lack of specificity about exactly how and when the risks identified would be ameliorated.
13. The witness therefore attended a further MRM on 29 November 2018 and a decision was taken to restrict admissions to the service and place time specific conditions that A had to prove that it had met. The deadline for completion was 6 December 2018. An Urgent Notice of Decision to that effect was issued on 30 November 2018 under section 31 of the Health and Social Care Act 2008 ('the Act').

The Inspection carried out on 6 December 2018

14. The witness set out the following concerns that were still found to exist during this follow up inspection by reference to the following regulations:
- a. Regulation 12 – Safe Care and Treatment
- i. Condition and cleanliness of the care environment:
- A had written to the CQC promising that exposed hot pipes and uncovered radiators had now all been fixed. However, CQC found that pipes and radiators were still exposed in corridors and in Service User's (SU) bedrooms. Some radiators were so hot that the inspectors could not touch them.
 - A had written to the CQC promising that all windows to which Sus had access now had restrictors fitted. However, CQC found that at least 2 windows had not been made safe. In relation to one window in room 18 the member of staff did not think it a risk as a SU would have to climb on a table to access the widow, However it was clear that SUs were using the

window for smoking. Moreover staff were not told of the location of the window restrictor keys.

- A had written to the CQC promising that a full infection control audit had been done and a deep clean company would be employed. However, CQC discovered that the company was unable to carry out a deep clean because of the condition of the Home.
 - Even though records supposedly showed that toilets had been cleaned the day before, nonetheless CQC discovered that there were still poor unclean bathrooms, toilets and en-suite facilities. Toilets and equipment to assist with mobility were dirty and apparently covered in faeces. A bathroom had a leak and smelt of damp.
 - Considerable mold and dirt were still to be seen in a bedroom and on the SU's belongings.
 - Broken glass was still seen to be near a bedroom.
 - During the inspection CQC inspectors spoke to members of the NHS infection prevention control team. They explained that a deep clean could not be undertaken until the Home was refurbished. Members of the team were in tears and visibly upset during the inspection at what they were seeing.
- iv. Poor standards of care:
- A had written to the CQC stating that support for SU in relation to personal and oral hygiene had been included in care plans. However, CQC discovered that one SU was wearing the same dirty clothes they had been wearing at the time of the last inspection.
 - Two other SUs was found to still have poor personal hygiene. Their fingernails were very dirty and they were unwashed. One of them still had poor oral hygiene and had not been provided with a toothbrush.
 - One SU told the inspectors that he "would rather be in prison". Others said that they did not feel safe.
- v. Risks relating to poor fire safety:
- A had written to the CQC stating that a full fire risk assessment had been done, especially in relation to the policy by which SU's could smoke and handle lighters. A stated that all lighters were kept in a locked cabinet. However, CQC discovered that SU's had their own cigarettes and lighters and that areas of the Home smelt of fresh cigarette smoke.
 - A stated that in relation to one high risk SU, he was checked every 15 minutes. However, CQC discovered that there was no written record of this policy and inspectors observed that this SU was not checked every 15 minutes as promised.
 - SUs were seen to be smoking outside the main entrance hall and a cigarette was extinguished on the entrance hall door mat.
 - There was also still a large degree of clutter and plugged in electrical items in rooms which still posed a risk.

- In relation to the SU who had barricaded himself in his room in the past, A's response was to seek his eviction.
- The CQC discovered that staff still did not have keys to access all rooms in the event of an emergency
- However CQC did discover that all service users now had a Personal Emergency Evacuation Plan

b. Regulation 18 – Staffing:

- A had written to the CQC stating that an accurate and up to date dependency tool had been put in place and that sufficient numbers of staff were now employed day and night. However, CQC discovered that staffing levels had not changed and the tool had not been used properly.
- No new staff had been employed.
- There were only 2 members of staff on duty overnight working a 14 hour shift. During some of that time only one staff member was on duty. This was inadequate.
- A had written to the CQC stating that a lone working policy and risk management plans had been put in place and that staff wore walkie talkies at all times. However, CQC discovered that there was no risk management plan provided during the inspection. Moreover some night shifts comprised only 2 females.

c. Regulation 17 – Good Governance:

- There was still a lack of quality audits. CQC inspectors were shown an environmental audit but it did not contain any action points and failed to identify the obvious and serious problems with the care environment.
- A told the CQC that they planned to refurbish the service but that this would take 9 months. There was no recognition of the urgency of the situation.
- There was still a problem with a lack of organised systems by the management team for the management of information relating to the Sus. The paper versions of the information being used by staff was still out of date.

15. The witness therefore attended a further MRM on 7 December 2018 and a decision was taken to vary the condition for the Regulated Activity of "Accommodation for persons who require nursing or personal care" to remove the Home from the conditions on the Certificate of Registration. The decision was set out in the Urgent Notice of Decision dated 10 December 2018 under section 31 of the Act. Before issuing the Notice, arrangements were made with NCC to rehouse all the SUs.

16. In cross examination the witness explained the factual accuracy process which led to the final version of the inspection report. There had been some amendments to the report as a result and she accepted that the lone working policy was in place at the relevant time, but nonetheless these matters did not change the position of the CQC. She also confirmed that she had fully

considered all the information from other organisations and the new evidence submitted by A about changes to the Home since the last inspection. She still stood by the decision of the CQC.

17. It was put to her that the NCC inspection had discovered different concerns to the CQC and also that they had discovered that staff were well versed in the Mental Capacity Act and the need for consent, and were able to explain how they should treat SUs with dignity and respect. Staff also thought that they had undergone appropriate training. The witness said that NCC had a different set of goals and that these findings did not alter what she saw on the 2 inspections she carried out at the Home. She added that the CQC had gone out of its way to give A every reasonable opportunity to comply with the regulations but they had failed to take those opportunities.
18. The Tribunal next heard oral evidence from **Ms. Kim Patience** who adopted her statement dated 15 January 2019 and explained that she was an inspection manager with the CQC and oversees a portfolio of services, managing a team of inspectors. She did not attend any of the inspections herself but had attended the various MRMs and was involved in the various decisions to issue notices against the A. In this latter respect she effectively repeated the evidence of the previous witness. She stood by the decision taken by the CQC and opined that there was no alternative course of action available.
19. In cross examination the witness explained the factual accuracy process which led to the final version of the inspection report and that she had fully considered the history of the Home and the new evidence submitted by A about changes to the Home since the last inspection. She still stood by the decision of the CQC. Despite assurances given by A, the result of the second inspection established that SUs at the Home were still at a risk of harm. She considered that A had been given sufficient time to deal with the risks and had failed to do so.
20. Moreover she said that A was under an obligation to abide by the Regulations from the date of registration and not merely respond to concerns brought to its attention by the CQC.
21. The Tribunal next heard oral evidence from **Ms. Jemima Burnage** who adopted her statement dated 11 January 2019 and explained that she was the Head of Inspection for Adult Social Care in the Central East of England Region for the CQC.
22. She had overall responsibility for the decisions in this case. She explained the methodology applied at the MRMs and how the decisions were taken collectively by all 3 witnesses using the Enforcement Decision Tree dated January 2017 which requires the CQC to consider the following criteria when selecting the appropriate action (Stage 3 of the Tree):
 - i. Seriousness of the concerns,
 - ii. Failure to act in the past,
 - iii. Evidence of multiple breaches,
 - iv. Evidence of persistent breaches,

- v. Inadequate leadership and governance;
23. The witness also produced the Enforcement Policy dated February 2015 which
- i. Deals with the need to consider in all such decisions proportionality and notes: *"...if the provider is able to improve the service on their own and the risks to people who use services are not immediate, we will generally work with them to improve standards rather than taking enforcement action. We generally intervene if people are at an unacceptable risk of harm or providers are repeatedly or seriously failing to comply with their legal obligations."*
 - ii. The Policy indicates various enforcement powers increasing in severity and that CQC's urgent civil enforcement powers are not at the top end of enforcement action;
 - iii. The Policy also specifically refers to the statutory test in Section 31 of the Act, namely that: *"We will use urgent procedures in line with the thresholds set out in the Health and Social Care Act 2008. This means that we will only use these powers where we believe that:*
 - *Unless there is an urgent use or amendment of conditions, or urgent suspension of registration, a person will or may be exposed to harm."*
24. The witness was adamant that the Notice of Decision was issued was reasonable and proportionate. She noted that the Local Authority Quality Assurance Team had visited the Home on 5 and 6 November 2018 to carry out an assessment of the quality of care provision and gave feedback on serious concerns 2 weeks prior to CQC's inspection on 27 November 2018 and despite this the necessary improvement steps had not been taken.
25. She stated that the CQC had adopted an incremental approach to enforcement and A had been given adequate time to take action to reduce the risks. In addition, the concerns identified by CQC were shared by NCC and NFRS. She also concluded that A had shown a lack of appreciation of the seriousness of the concerns identified by CQC. She also noted that A had a "patchy" compliance history in respect of the Home and A had had no Registered Manager in place since November 2017.
26. She confirmed that during the last MRM and applying the decision tree it was concluded that A had not taken the necessary steps to reduce the risk to SUs. She said that there remained a risk of harm, which was deemed to be "Major", and the likelihood of recurrence was "Probable". The seriousness of the concern was "Extreme". She was sure that the test of there being a risk of harm to justify urgent removal of the location of the Home had been met. In fact she concluded that there was a risk of serious harm which in some circumstances would require a cancellation of registration.
27. In cross examination she further explained why a Section 31 urgent variation of a condition of registration was the appropriate course of action. The risk required urgent action but it was not proportionate to cancel registration as A was a Registered Provider with 2 registered locations. The serious concerns found by the CQC were specific to the Home and by removing the Home as a

location by the variation of a condition of registration this enabled A to retain Baytree Lodge as a location on its registration.

28. She also explained the factual accuracy process which led to the final version of the inspection report and confirmed that she had fully considered the history of the Home and the new evidence submitted by A about changes to the home since the last inspection. She still stood by the decision of the CQC.
29. She agreed that it was now very difficult for the CQC to assess whether the changes supposedly made to the home were adequate to ameliorate the risk of harm because there were no SUs in the Home and no registered services were being provided. However she did not agree that A was in a “Catch 22” situation as A’s remedy was that he could simply apply anew for registration. If A made such an application the CQC would consider all relevant factors including the history of the Home and the evidence of work done more recently.
30. The panel then heard evidence from **Mr. Chhaganbhai Mistry** who adopted his witness statement dated 17/01/19 which stated that he was the Nominated Individual and Director of the Home and had been since 2006. He gave details of his qualifications and history within the care system. He also gave details of the history of past inspections at the Home and said that he thought that he had a good track record of complying with problems raised by the CQC in previous inspections. In April 2017 the Home was rated as Good in all areas.
31. In cross examination he agreed that in fact the Home had never had consecutive inspections without a breach of the Regulations being found by the CQC. He replied, “Yes but I didn’t sit on my hands”. He added, “when something was found wanting, we responded.” He said, “I blame poor leadership”. He agreed that the CQC was a regulator and not a supervisor. He agreed with the proposition that it was not their role to alert him to areas where he was non-compliant. It was his job to know the content of and apply the Regulations.
32. He explained how due to a series of unfortunate events there had been no registered manager at the Home since December 2017. He had employed interim managers but there had always been problems. He had 4 homes in total located throughout the UK and he spent a disproportionate amount of his time dealing with the Home in Norfolk (even though he lived in London) because the “system did not work” during the times without proper management. He would visit the Home to “steady the ship” and was surprised “how things can go topsy turvy so quickly” but he did not see it as his role to “micro-manage” the place.
33. He said that prior to the CQC inspection in November 2018 he was not aware of any problems with hot radiators and exposed pipes. He appeared to deny there was a problem as he said, “to me the radiators were not that hot that they should be covered.” He said because the issue had not been highlighted during previous inspections “I would assume it was a safe place.” However, he then accepted that the radiators were too hot to place your hand on.
34. He said that he had known since October 2018 that the windows did not have restrictors. He claimed that the window installers had breached their contract to

provide them when new windows were fitted in 2017. He knew he should have replaced them earlier. He said “It was a slip up on my part. I should have been more vigilant.” In cross examination he accepted that the lack of restrictors did pose a risk to SUs but he said, “most SUs had been risk assessed.....we didn’t have people who would try and jump out of windows.” He then said that all SUs were risk assessed.

35. He said that he could not remember when he was told by staff about problems with SUs smoking in an around the Home. He was told that all lighters were securely held in the office but he did not “micro-manage” people. It was put to him that the CQC inspectors saw SUs with lighters and smoking cigarettes. He responded by saying “the CQC assumed that it was probable. I say it was not possible [sic].” He did not know that personal evacuation plans were not in place for all SUs until the CQC found out during the November 2018 inspection.
36. In cross examination he said that SU1 did not barricade himself in his room “regularly”. He had only done it twice and he only did it “to send a message.” The witness believed that this did not cause a risk of harm in case of a fire because he had replaced the carpet in his room with linoleum. He thought that this made it easier to open the door in case of further barricading.
37. He was also aware of a number of SU’s who had problems with personal and oral hygiene. He later clarified that he did not know until the CQC carried out the November 2018 inspection. He said that the problem was that some SUs refused to cooperate with staff and there were issues of personal liberty in forcing them to keep clean against their will. He knew one SU was not provided with a tooth brush but he felt that the person should buy his own as then he would be more likely to use it.
38. He was not aware of the unhygienic and dirty conditions in the bathrooms and toilets as he “did not have an eye for that sort of thing”. The Home employed one cleaner who was supposed to work 6 days a week and was responsible for cleaning (inter alia) 14 bathrooms and toilets and 22 bedrooms. The witness said that he was not happy with the cleaner’s work and had not been happy since 2017. He said he was aware of damp in some bathrooms in October 2018 and he planned remedial work. The witness said, “We have learned our lessons.”
39. He was shown photos of the room where there was a serious damp problem and where a SU’s belongings and shoes were covered in mold. The witness said that he was told by the manager that the SU had left the room in October 2018 and had left his possessions in the room, not because they were covered in mold but because he no longer wanted them. He said that if someone had been living in that room in that condition they would have been at risk of infection. However, he was adamant that the SU had moved out in October 2018. Later it was admitted by A’s representative that in fact a SU was still living in that room on 27 or 28 November 2018.
40. Mr. Mistry said that he and his team had done their best to take remedial action after the first inspection. He said that (inter alia) most of the radiators had been

covered and that all the windows to which SUs had access had restrictors fitted. In particular, 62 of the 65 window restrictors were fitted, all radiators in communal areas were covered and reviews conducted of all bedroom radiators.

41. In addition, action had been taken to clean the Home and NFRS had inspected the premises again and said that many of the defects had now been rectified. Personal evacuation plans were now in place for all SUs. He said that he had used a dependency tool and that this indicated that the Home had adequate staffing levels. He also said that a cross infection nurse had visited the Home on 24/01/19 but no report was submitted to the Tribunal.
42. He said "I should have woken up much earlier but now we have realised that our internal audit has not worked. We have now decided to employ an external auditor to visit every 6 months." He added, "the buck stops with me and lessons have been learned." However, he said the CQC had overreacted and "I think we were never very seriously in breach in the past. It was only ever requires improvement." He also criticised the way in which the CQC inspectors behaved saying that "they did not listen to explanations, no clarification was sought and only limited documentation was reviewed". However no allegation of bad faith was made against the CQC on behalf of the A.
43. He was asked whether he thought that any breach of a Regulation was a serious matter? He responded by saying, "Yes I do. I think we were an average service." He was asked whether any of the findings of the CQC in their inspections in November and December 2018 indicated a risk of harm to persons at the Home. He replied, "No there was no immediate risk of harm from fire." He was asked, "Was there some risk of harm to persons?" and he replied, "Yes of course." He was then asked, "what risk do you think there was concerning fire safety?" he replied, "I couldn't figure it out." He then said that there was no risk of a fire. He did accept that if toilet seats and equipment were dirty and soiled with faeces then that would cause a risk of infection. There would also be such a risk if there was no sink in the medicine room and where SUs were not changing their clothes and following good hygiene practices.
44. He knew that there had been instances where only 2 female members of staff had been on duty overnight working a 14 hour shift and that during some of that time only one staff member was on duty, despite there being a lone working policy and risk management plan. He said that "normally" the second staff member would not be asleep during the shift. He appeared not to agree that the policy was necessary and thought that the practice of having only two female staff was perfectly safe. He said, "I don't see why a man would offer more security than a female." He thought that as the lone working policy and risk management plan were not mandatory it was not necessary to follow them all the time. He agreed that 2 staff were not enough to cover a 14 hour shift. He needed more staff but he had not yet worked out exactly how many more were needed
45. He said that a lot of work had been done at the Home since the December 2018 inspection. On 20th December 2018, Claire Pilkington had confirmed that she would join as full-time manager and took up the role on 2nd January 2019.

He had interviewed her and was very impressed by her CV. He believed that she had 19 years of experience in the care industry, including the management of a residential home which she navigated to CQC compliance within 6 months' of assuming the management position. That's what it said on her CV and he did not think it necessary to check for himself by reviewing the relevant CQC reports. He had also employed Rachel Nemchand, an independent consultant from Mabon & Ray, who was helping improve the Home. He was asked, "What assurances can you give that these breaches won't happen again?" The witness replied, "I am quite confident with my experience that we will be able to resolve this."

46. The Tribunal next heard oral evidence from **Ms. Rachel Nemchand** who adopted her statement dated 17 January 2019 and explained that she was a consultant for care homes and had started working for A on 10 December 2018. She had been a consultant since December 2017. She had a level 5 health and social care qualification. She had owned and run care homes in the past and helped others who owned homes. She had visited A's Home on 2 occasions and helped draw up an action plan to improve things there. She produced copies of the audit and action plan which the panel read. She thought that Mr. Mistry was very motivated and proactive. Ms Nemchand considered that the areas requiring improvement, included infection control and health and safety.
47. In cross examination she said that she had read the findings of the CQC's inspection. She agreed that on the basis of their findings there would have been a risk of harm to persons at the Home from burning themselves on hot exposed pipes and hot radiators without covers and also a risk of harm from fire because of bad smoking practices. When she attended she could still smell fresh smoke inside. She also said that the problems with the room with mold should have been dealt with much earlier and the state of the bathrooms was particularly poor.
48. The Tribunal next heard oral evidence from **Ms. Claire Pilkington** who adopted her statement dated 17 January 2019 and explained that she became full time manager of the Home on 2nd January 2019. She reiterated in her witness statement that the last home she had managed (Wainford House) had been non-compliant and she had navigated it to CQC compliance within 6 months' of assuming the position in December 2013. In cross examination she accepted that in fact after that 6 month period the home fell back into non-compliance again. The witness agreed the following:
 - a. In a CQC inspection in October 2015 the home was found to be non-compliant in a number of areas including inadequate in the area of "well led"
 - b. In a CQC inspection in February 2016 the home was found to be non-compliant in a number of areas including inadequate in the areas of "well led" and "safe".
 - c. In a CQC inspection in July 2016 the home was rated as "requires improvement" overall and "requires improvement" in the area of "well led" but was good in relation to the area of "safe".

49. She accepted that she had never managed a care home that had been assessed as good overall under the new system. She did not agree that she was trying to mislead the Tribunal by not explaining all of this in her witness statement. She stated that she had told Mr. Mistry in her job interview that she had turned around a failing care home in 6 months and had never told him about what happened to it after that time. He had never asked her further questions about it and she did not feel it necessary to make such full disclosure voluntarily. She explained, "I didn't go into the details of my issues with inspections during the job interview. I wasn't proud of it."
50. In cross examination she said that she had read the findings of the CQC's inspection of the A's Home. She agreed that on the basis of their findings there would have been a risk of harm to persons at the Home from infection and fire. She also stated that the lack of window restrictors would have posed a risk of harm and the lack of appropriate staffing levels and safety especially during night shifts.
51. She had been liaising with Ms Nemchand and helped draw up an action plan to improve things at the Home. She produced copies of new form templates and management tools that they planned to use in the future. They had employed 2 new part time cleaners and she anticipated that the refurbishment programme of the buildings would be completed by March 2018. She said that she only had "very limited" experience in the past of dealing with people having complex mental health needs. However she was positive that she could turn the Home round and make it compliant again.
52. The panel then heard oral submissions from both representatives which we noted and have taken into account.

Legal Framework

53. Section 31 of the Act deals with the urgent procedure for suspension and variation of conditions:
- "(1) If the Commission has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm, the Commission may, by giving notice in writing under this section to a person registered as a service provider or manager in respect of the regulated activity, provide for any decision of the Commission that is mentioned in subsection (2) to take effect from the time when the notice is given.*
- (2) Those decisions are –*
- (a) a decision under section 12(5) or 5(5) to vary or remove a condition for the time being in force in relation to the registration or to impose an additional condition;*
 - (b) a decision under section 18 to suspend the registration or extend a period of suspension."*

The Tribunal's powers on appeal

54. An appeal against a decision lies under section 32(1)(a) of the 2008 Act. On consideration of the appeal the panel may confirm the decision or direct that it is not to have effect (section 32(5) of the Act). Under section 32 (6) the panel also has power to vary any discretionary condition for the time being in force in

respect of the regulated activity to which the appeal relates. A “discretionary condition” means any condition other than a registered manager condition required by section 13(1)).

The Burden and Standard of Proof

55. In so far as any past facts are relevant and/or in issue the Respondent bears the burden of proof and the standard is the balance of probabilities.
56. The burden rests with the Respondent to show, on the balance of probabilities, that each of conditions proposed is necessary and proportionate. The ultimate issue involves a judgement as to the existence and significance of any risk, as viewed today, on the basis of all the material before us, including any findings we may make in relation to past facts.
57. The overarching issue to be addressed by the tribunal is whether, at the date of the hearing, there is reasonable cause to believe that, unless conditions are imposed, any person will or may be exposed to the risk of harm.

Conclusions

58. For reasons given below the panel concludes that the Respondent has proved to the requisite standard that the test (of there having been a risk of harm to justify urgent variation of the condition of registration so that the regulated activity of “accommodation for persons who require nursing or personal care” may not be carried out at the Home) was met.
59. The panel was impressed by the honesty and reliability of the CQC’s witnesses and are satisfied that the inspections of the Home carried out in November and December 2018 by the CQC were undertaken fairly, professionally and proportionately. We accept that the findings as recorded in the final CQC report (and as explained to us under oath and supported by photographic evidence) were accurate, fair and reliable. We acknowledge that as a result of the factual accuracy process some of the findings were amended to reflect further information submitted but we conclude that these amendments were relatively minor and do not alter the gravamen of the CQC findings.
60. The findings of the first inspection in November 2018 paint a very concerning picture of a lack of basic care and safety. We are satisfied on the balance of probabilities that the state of the Home and the services provided within it presented a risk of harm to SUs and staff. The evidence is set out in extenso above and we do not propose to repeat it all again. To a large extent it speaks for itself. The CQC (and indeed other agencies) found serious shortcomings in the areas of (inter alia) fire safety, safety around windows, radiators and pipes as well as a lack of cleanliness and poor personal hygiene. Both Claire Pilkington and Rachel Nemchand accepted that the CQC findings indicated that persons at the Home were at risk of harm. Rachel Nemchand in her oral evidence said that on the basis of the CQC’s findings there would have been a risk of harm to persons at the Home from burning themselves on hot exposed pipes and hot radiators without covers and also a risk of harm from fire because of bad smoking practices.

61. Claire Pilkington in oral evidence said that on the basis of the CQC's findings there would have been a risk of harm to persons at the Home from infection and fire. She also stated that the lack of window restrictors would have posed a risk of harm and the lack of appropriate staffing levels and safety especially during night shifts could have exposed persons to the risk of harm.
62. Even Mr. Mistry agreed at one stage that a person living in the damp room with mold would have been at risk of infection. He also accepted that if toilet seats and equipment were dirty and soiled with faeces (as the panel is satisfied they were) then that would cause a risk of infection. There would also be such a risk if there was no sink in the medicine room (as the panel is satisfied there was not) and SUs were not changing their clothes and following good hygiene practices (as the panel is satisfied they were not).
63. It may be that NFRS and NCC found different defects and had different views about defects found by the CQC, but the panel concludes that the findings of the CQC are genuine and reliable.
64. The panel is also satisfied that a risk of harm to persons at the Home still existed at the time of the CQC inspection in December 2018. There were still poor unclean bathrooms, toilets and en-suite facilities. Toilets and equipment to assist with mobility were dirty and apparently covered in faeces. A bathroom had a leak and smelt of damp. Radiators and pipes were still posing a risk of burning SUs. Not all of the windows had the necessary restrictors on them. It is not good enough for Mr. Mistry to say that there was no reason to believe that SUs would jump out of windows because there was still a risk they could fall out. Moreover staffing levels had not improved and SUs were still showing very poor personal and oral hygiene and continuing with the dangerous activities surrounding smoking and use of lighters. The panel found it particularly powerful evidence that during the latter inspection CQC inspectors spoke to members of the NHS infection prevention control team some of whom were in tears and visibly upset during the inspection at what they were seeing.
65. In light of all the evidence above therefore the panel is satisfied that when the CQC made the decision under appeal, there was a risk of harm to persons at the Home. In addition, for reasons given below the panel is satisfied on the balance of probabilities that it was necessary and proportionate for the CQC to take this decision when it did, in order to protect persons in the Home from such a risk.
66. First the panel concludes that in light of the evidence and the nature of the risk of harm it was reasonable and proportionate for the CQC to give A only limited time to try and put things right before taking further action. This is especially so, as the panel finds that Mr. Mistry had knowledge of a number of the serious problems (such as the windows, fire safety problems and hygiene issues) well before the November 2018 inspection.
67. In addition the panel concludes that in light of the evidence and the nature of the risk of harm it was reasonable and proportionate (and in line with its own published policies and procedures) for the CQC to make the final decision that

it did. The breaches were serious, persistent and multiple. There was evidence of inadequate leadership and governance and failures by A to act in the past. The Home has never had consecutive inspections without a breach of the Regulations being found by the CQC.

68. The panel also accepts the evidence of Ms. Jemima Burnage that a section 31 urgent variation of a condition of registration was the appropriate course of action in this case. The panel is satisfied to the requisite standard that the risk required urgent action but it was not proportionate to cancel registration outright as A was a Registered Provider with 2 registered locations. The serious concerns found by the CQC were specific to the Home and by removing the Home as a location by the variation of a condition of registration this enabled A to retain Baytree Lodge as a location on its registration. This is entirely proper and fair. The panel does not agree with the A's submission that this was a ploy to try and gain advantage by applying a lower test of harm as opposed to serious harm. In fact the panel agrees with the analysis of the CQC that there was a risk of serious harm in any event.
69. The next question for the panel therefore is whether the CQC has proved on the balance of probabilities that as at the date of the hearing, unless the condition prohibiting the provision of services at the Home is continued any person will or may be exposed to the risk of harm.
70. For reasons given below the panel concludes that the CQC has proved on the balance of probabilities that Mr. Mistry and his new team are unwilling or unable to protect persons at the Home from the risk of harm. First, the panel concludes that despite some remedial work having been undertaken and planned, it has been established that Mr. Mistry still does not fully understand the seriousness of the risk of harm that was created at the Home. We conclude that he is still in denial and despite his protestations to the contrary has not learned the appropriate lessons. He seems to blame the CQC and lack of management in the Home, even though he holds ultimate responsibility.
71. In particular we were very concerned that he thought that he had a good track record with the CQC even though that record showed a lack of proactive engagement with the Regulations. He said he was good at complying with problems raised by the CQC, but we consider that this is not the proper approach to his responsibilities. It is not the role of the CQC to alert him to areas where he is non-compliant. It is his responsibility to know the content of and apply the Regulations. His past history shows an inability to do this in the past in relation to the Home which has never had consecutive inspections without a breach of the Regulations being found by the CQC.
72. Moreover we were very concerned that Mr. Mistry showed an inability to learn lessons because of his vague and inconsistent oral evidence about the findings of the CQC in many areas. For example, he appeared to deny there was a problem with the radiators as he said, "to me the radiators were not that hot that they should be covered." He then accepted that the radiators were too hot to place your hand on. Moreover, in cross examination he accepted that the lack of window restrictors did pose a risk to SUs but he said, "most SUs had been

risk assessed.....we didn't have people who would try and jump out of windows." He then said that all SUs were risk assessed. In addition, when it was put to him that the CQC inspectors saw SUs with lighters and smoking cigarettes, he seemed to deny this was a problem because "the CQC assumed that it was probable. I say it was not possible [sic]"

73. Moreover we conclude that Mr. Mistry still does not understand the nature of the risks arising in connection with the SU who had barricaded his room in the past. The belief that simply changing the flooring from carpet to linoleum would extinguish the risk is indicative of a lack of understanding of the nature and seriousness of that risk.
74. In addition his lack of understanding is further evidenced by his declared belief in his oral evidence that it was expedient to simply ignore the lone working policy and risk management plan and he could still see no problem with having only two female staff on duty at night during a 14 hour shift. His lack of appreciation of the risk of harm to staff is further evidenced by his assertion that "I don't see why a man would offer more security than a female."
75. For reasons given below the panel concludes that the CQC has also proved on the balance of probabilities that Ms. Pilkington and Ms. Nemchand are unlikely to be able to protect persons at the Home from the risk of harm. In reality Ms. Nemchand has very little practical experience of turning around a home that has such problems and which is supposed to provide services to persons with complex mental health needs. She has only been a consultant since December 2017 and her only relevant qualifications are a level 5 health and social care qualification. We acknowledge that she had owned and run care homes in the past and helped others who owned homes, but she has only visited A's Home on 2 occasions and it was unclear as to how much practical day to day help she would be able to give.
76. In addition Ms. Pilkington has by her own admission only had "very limited" experience in the past of dealing with people with complex mental health needs. Moreover she accepted that she had never managed a care home that had been assessed as good overall under the new system. In addition the panel are satisfied that she was "economical with the truth" when she told Mr. Mistry in her job interview (and stated in her witness statement) that she had turned around a failing care home in 6 months but made no mention of what happened to it after that time. We accept that she told the whole truth when asked about it under oath but it is clear that during the job interview, Mr. Mistry had never asked her further questions about it and she did not feel it necessary to make such full disclosure voluntarily. We accept her explanation that, "I didn't go into the details of my issues with inspections during the job interview. I wasn't proud of it." This course of conduct also highlights a lack of rigour, leadership and judgement on behalf of Mr. Mistry in that he did not ask her further questions or check the CQC reports about her previous care home.
77. In light of all the aforesaid findings therefore, the panel is satisfied on the balance of probabilities that all aspects of the test have been met and the appeal must be dismissed.

Decision

The decision to impose conditions on registration, as varied above, is confirmed and the appeal is dismissed.

**Tribunal Judge Timothy Thorne
Care Standards
First-tier Tribunal (Health Education and Social Care)**

Date Issued: 01 February 2019