

First-tier Tribunal Care Standards

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

**NCN: [2021] UKFTT 1 (HESC)
[2019] 3889.EA VKinly**

Hearing held by video link
on 8, 9, 10 and 11 December 2020

BEFORE

**Ms S Brownlee (Tribunal Judge)
Ms Denise Forshaw (Specialist Member)
Ms Lorna Jacobs (Specialist Member)**

BETWEEN:-

Sonia Heway Care Agency Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. Mr Kenneth Fawole, the nominated individual and director of Sonia Heway Care Agency Limited ('Sonia Heway') ('the Appellant'), appeals pursuant to section 32 of the Health and Social Care Act 2008 ('the Act'), to the Tribunal. The appeal relates to a decision of the Care Quality Commission ('the Respondent') dated 22 October 2019 to cancel the registration of the Appellant in respect of the regulated activity 'personal care' at Sonia Heway Care Agency Limited, Thames Innovation Centre, 2 Veridion Way, Erith, Kent DA18 4AL.

The Hearing

2. The hearing took place on 8, 9, 10 and 11 December 2020. This was a remote hearing which was not objected to by the parties. The form of remote hearing was by Kinly CVP video. A face to face hearing was not held because it was not practicable and no-one requested the same. We considered that the issues

in this appeal could be determined in a remote hearing. The documents that we were referred to are in the electronic hearing bundle provided in advance of the hearing. Page references follow the pagination on the original bundle for ease of reference, as some participants were working from a hard copy bundle and some from a digital bundle.

3. There were no significant connectivity issues during the hearing. All participants were able to connect their video and audio throughout. At times, there was some reverberation, which was inevitable, given that Mr Fawole, Ms Hamilton and Mrs Egunjobi were based in one room. With some adjustments, this issue did not impact very much at all and certainly did not inhibit the participants' ability to hear the relevant participants.

Attendance

4. Mr Fawole, the Appellant, was represented by Ms Amanda Hamilton of Counsel, instructed by Royds Withy King Solicitors. Mr Fawole called one witness: Mrs Titilayo Egunjobi, who is currently the Acting Registered Manager at Sonia Heway. The CQC, the Respondent, was represented by Mr Simon Walters of Counsel, instructed by Legal Services, Care Quality Commission and assisted by Mr Toby Buxton. The Respondent called three witnesses: Ms Anastasia Appah and Mr Andrew Scott, Inspectors and Ms Natalie Reed, Inspection Manager at the CQC.
5. There were observers at various points over the course of the public hearing.

Background

6. Sonia Heway has been registered with the CQC since 1 October 2010, to carry out the regulated activity of personal care, initially at a location in Bexleyheath and then, from 1 December 2017 onwards, at its current location. From 23 March 2011, Mr Fawole was registered as the manager of the service. Mrs Doreen Ukas was added as a second registered manager on 19 October 2018.
7. By the time of the inspection of July 2019, Mrs Ukas and Mr Fawole were the two registered managers of the service. The service has a wider regulatory history, which is of relevance to this appeal. On 30 and 31 March 2015, an announced comprehensive inspection resulted in breaches of Regulations 13, 9, 10, 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with an overall rating of inadequate, special measures imposed and a warning notice was issued for Regulation 13 (safeguarding service users from abuse and improper treatment). On 9 July 2015, a follow up focused and announced inspection on breach 13 only established that the serious safeguarding concerns had been addressed, but the service remained inadequate and in special measures.
8. On 22 and 23 October 2015, the service was subject to an announced comprehensive inspection which established breaches of Regulations 9, 17, 12 and 18 with an overall rating of requires improvement and inadequate in safe

care and treatment (Regulation 12). The service remained in special measures and a further warning notice was issued.

9. On 5 April 2016, there was an announced, focused inspection of Regulation 12 and the serious concerns were found to be addressed. On 24 August 2016, the service was subject to an announced comprehensive inspection and was found in breach of Regulations 9, 12 and 17, with an overall rating of inadequate, the service remained in special measures and a condition was added to the service's registration.
10. On 12 April 2017, the service was subject to an announced comprehensive inspection with breach of Regulation 17 identified and an overall rating of requires improvement imposed. The service was removed from special measures but issued with a requirement notice for Regulation 17. On 21 June 2018, the service was subject to an announced comprehensive inspection and the service was found to be in breach of Regulations 12 and 17 with an overall rating of requires improvement and a requirement notice was issued for both Regulations.
11. In June 2019, the CQC received information from Lambeth London Borough Council relating to serious safeguarding incident involving a service user (M). Carers from Sonia Heway failed to attend M's home on 9 and 10 March 2019. M had a fall over that weekend and remained on the floor for most of the weekend which resulted in permanent damage to their right leg and damage caused to M's kidney function due to their catheter not being attended to through the weekend period. The service was due for a comprehensive inspection at the end of July 2019, so a decision was made to move the inspection forward to 11 and 12 July 2019.
12. After the two-day inspection, which was conducted by Ms Appah and Mr Scott, the service was found to be in breach of Regulations 9, 10, 12, 13, 16, 17, 18 and 19 with an overall rating of inadequate and the service placed in special measures. On 17 July 2019, the Respondent issued a Notice of Decision to impose a condition on the Appellant's registration so that the Appellant could not provide personal care to any new service user without the prior written agreement of the CQC. On 2 August 2019, the Respondent issued a Notice of Proposal to cancel the Appellant's registration and cancel the registration of the two registered managers, Mrs Ukas and Mr Fawole. Written representations were received on 3 September 2019 in relation to the proposal to cancel the registration of the service. No representations were received in relation to the proposal to cancel the registration of the two registered managers. On 22 October 2019, the Respondent issued a Notice of Decision to cancel the Appellant's registration.
13. On 18 November 2019, the Appellant appealed the Respondent's decision to the First-tier Tribunal.
14. Since the commencement of the appeal, the Respondent has conducted three further inspections of Sonia Heway. On 22 and 23 January 2020, the Respondent's announced, comprehensive inspection found breaches of

Regulations 9, 12, 13, 16, 17, 18 and 19 with an overall rating of inadequate and continuation of special measures. On 29 July 2020, the Respondent conducted an announced, focused inspection and found breaches of Regulations 9, 12 and 17. On 7 and 9 October 2020, the service was subject to a targeted inspection after an anonymous concern was raised about a number of service users. The service was found to be in breach of Regulation 17.

Legal Framework

15. Section 3 of the Health and Social Care Act 2008 ('the Act') invests in the Respondent registration functions under Chapter 2.
16. By virtue of section 3(1) of the Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.
17. Section 4 of the Act sets out the matters to which the Respondent must have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.
18. Section 17 of the Act gives the CQC the power to cancel the registration of a service provider of a regulated activity on the grounds that the regulated activity is being or has at any time been carried on otherwise than in accordance with the relevant requirements. Relevant requirements include any conditions imposed by or under Chapter 2 and the requirements of any other enactments which appear to be relevant to the Respondent – i.e. the 2008 Regulations.
19. Under section 20 of the Act, the Secretary of State is empowered to make regulations in relation to the regulated activities by way of regulations. The Regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ('the Regulations') and The CQC (Registration) Regulations 2009.
20. Sections 26, 27 and 28 of the Act set out the procedural requirements in relation to notification of the Respondent's decision.
21. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to cancel the registration of a service providing a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect, or to vary, cancel or impose any conditions on the registration that the Tribunal sees fit.
22. The Respondent bears the burden of persuading the Tribunal that cancellation of the service is a proportionate decision. The Respondent must establish the facts upon which he relies to support satisfaction of the proportionality of the

decision on the balance of probabilities.

23. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing and thus may take into account evidence which post-dates the notice of decision (subject to fair notice).

Late Evidence

24. At the beginning of the hearing, Ms Hamilton applied to admit a number of documents as late evidence. She indicated that Mrs Egunjobi would provide further information on the documents in due course. They consisted of a nurse buddy printout from November 2020, a grab sheet for service user AU from 17 July 2020 and daily task notes from 8 and 13 August 2020. During the course of the hearing, we also received a copy of a service user's hospital passport and an email chain between Mrs Egunjobi and Ms Reed from October 2020. There was no objection from the Respondent, so we duly admitted the late evidence as it was of relevance to allegations which were denied by the Appellant and Mrs Egunjobi was attending to provide oral evidence; any points arising from the documents could be tested with Mrs Egunjobi.

Issues

25. The key question for the Tribunal is whether the Respondent is able to demonstrate, on the balance of probabilities, that the decision to issue a decision to cancel the registration of the Appellant remains a proportionate and reasonable one, when considered alongside the requirements in sections 3, 4 and 17.

The Appellant's position

26. The Appellant has accepted many of the breaches found during the inspections of July 2019, January 2020 and July 2020. The Appellant contends that it has worked responsively to address the failures and has managed to put in place considerable improvements to such an extent that it is no longer in breach of Regulations 9, 10, 12, 13, 16, 18 and 19. Ultimately, the Appellant does not accept that the service remains in breach of Regulation 17, considers that the Respondent has failed to give any or sufficient weight to the improvements made to the service and has failed to acknowledge the improvements to alter the overall rating to the service. During the course of the hearing, it became clear that the Appellant is also confident that with more time, the service will be able to achieve a better rating.
27. The Appellant requests that the Tribunal should direct that the decision ceases to have effect with the need for a review of the discretionary conditions.

The Respondent's position

28. The Respondent submits that the decision to cancel the Appellant's registration should be confirmed, as a decision that remains justified, reasonable and proportionate given the Appellant's poor history of compliance with the

requirements of the 2008 Act and the 2014 Regulations.

29. In the alternative, the Respondent submits that if the Tribunal disagrees and directs that the decision to cancel registration should cease to have effect, the current conditions should remain in place.

Evidence

30. We considered all the evidence that was presented in the bundle and at the hearing. We have summarised the evidence insofar as it relates to the relevant issues for the Tribunal. What is set out below is not a reflection of everything that was said or presented at the hearing or in the hearing bundle.
31. We heard oral evidence from Ms Appah, Mr Scott, Ms Reed, Mr Fawole and Mrs Egunjobi. We also carefully considered the witness statements of Ms Maria Goncalves, who is the registered manager at Sonia Heway, but is currently on sickness absence, Ms Charlotte Jones, Care and Clinical Director and Ms Vanessa Padgett, Quality Assurance Lead - both at BKR Care Consultancy Ltd.
32. Ms Appah and Mr Scott both made the point that when they attend inspections, they do so with an open mind – hoping for improvements based on an awareness of the service’s previous regulatory history. Ms Appah commented that she would attend the service for each inspection with high hopes and would leave thinking – what is happening here?
33. When they attended for the first relevant inspection in July 2019, it was as a result of a serious complaint about the standard of care to a service user who was left with kidney damage as a result of the failure to visit and provide catheter care over two days. Ms Appah focused on reviewing the processes and documentation in place to ensure care was being delivered to the appropriate standard and risk was being managed. She observed that staff were not working well together – she noted that she could hear the frustration in the voices of the care coordinators when telling her that they scheduled visits and the carer staff attend when they want to, did not inform the coordinators if they were running late, cancelled visits at the last minute – advising that it was impacting on the care planning as the coordinators had to try to cover the gaps when carers did not do their jobs. Ms Appah also noted that there was no evidence of performance management at the time of the July 2019 inspection. By the time of the January 2020 inspection, there had been changes but the staff were still not following the requirements which was making improvements difficult. The care plans and documentation remained concerning for Ms Appah, using the example of service user AL’s care plan which made no reference to the specific triggers for AL’s aggression.
34. By the time of the July 2020 inspection, Ms Appah observed that the management structure, which was explained to her by Mr Fawole, did not appear to work; there seemed to be disagreement and a lack of accountability. Ms Appah cited the example of Ms Goncalves, who, having reviewed a care plan, noted an error and left a post-it note for someone else to pick up the issue and correct it. In Ms Appah’s opinion, in light of Ms Goncalves’ role, she should

have rectified that issue as she saw it. For Ms Appah, this was an example of the team not working towards the same goal and demonstrated the friction with the team. She commented that Mr Fawole did not appear to have oversight of the systems in place and did not conduct audits. This surprised her, given his role as the nominated individual and the recent developments with the service's registration as a result of the inspection of July 2019. Ms Appah considered that Mr Fawole relied on feedback from staff. By July 2020, the service had 15 service users and she expected Mr Fawole to know the service 'at his fingertips'. She approximated that reviewing two care plans per day would take three hours to audit, review and update until the quality was acceptable.

35. Another area of concern at the July 2020 inspection was the lack of sufficient guidance for staff on the updated procedures for visits during the Covid-19 pandemic. Ms Appah acknowledged that after the inspection, Ms Goncalves sent through the new, correct guidance, but the concern remained for Ms Appah – at the time of the inspection, the guidance was not correct, irrespective of what she was told the staff were actually doing on their visits. Ms Appah also had concerns that Ms Goncalves was not clear on the procedure for notification to the CQC of pressure sores of a grade 3 and above – Ms Goncalves believed she was not required to notify the CQC until after the local authority had notified the service.
36. By the time of the inspection of July 2020, when the service had 15 service users, Ms Appah was of the view that she should not have found anything wrong, given the staff to service user ratio. By the time of the July 2020 inspection, the last one she attended, she was of the view that the service had 'no way back'. She considered that if they had not made the required improvements after the three inspections and with the lessening number of service users, she was not sure how much more the service could do to get it right. She indicated that she became more disappointed with each outcome as she had real concerns that with 15 service users, they still could not get the service right and she had concerns with what would happen if the service took on more people. She did not accept that she made judgments of the service in advance of the inspections. Ms Appah stated that each time an inspection took place and some improvements were noted, the decision to cancel was reviewed, indicating that if the CQC had changed its view of the service, after a management review meeting (after each inspection), it would have withdrawn the decision to cancel registration.
37. Mr Scott fulfilled the role of second inspector for the inspections of July 2019, as well as January, July and October 2020. He was previously aware of the service, having been a second inspector in 2016. He reviewed complaint handling as part of the inspection, as well as the electronic care management ('ECM') system. The regulations, as well as local authorities, require that there is a system for receiving, handling and resolving complaints and that all that information is present for the inspection. Mr Scott was never shown a communication log and was not able to identify if complaints had been resolved. He noted, as an example, service user AS – a relative of AS had complained on three occasions – rolling from July 2019 to January 2020 – regarding missed visits. By July 2020, Mr Scott noted an improvement, but also noted that by

that stage, the local authorities had placed a significant number of service users with other providers, leading to the reduction to 15 service users who, in his view, were less concerned about the times of their visits.

38. At the January 2020 inspection, Mr Scott was informed that the service did not have any complaints to address, but during the inspection, he was handed complaint information which showed there were still issues. He queried this with Mr Fawole who did not give him a response. By the time of the January 2020 inspection, Mr Fawole had engaged the consultancy services of BRK. Mr Scott found the process of the inspection to be quite challenging as he was not provided with the answers to the specific questions he asked and as the inspection is time limited he would have to move on to the next matter without receiving the information he expected.
39. As of the January 2020 inspection, Mr Scott noted that staff member D had missed a visit and he wished to know what follow up there had been over the issue. Mr Acquah told him that staff member D would have attended a supervision meeting over the issue. Mr Acquah could not locate the supervision record despite searching for it on the system for quite some time. On the same day, after the inspection visit, Mr Scott received a PDF document of the supervision record which had a date of generation for that same day. Ultimately, he was sceptical as to how and when this document had been generated and queried this – wishing to see the original document, on the basis that he understood that the document may very well have been generated in that particular format on that day. A colleague of Mr Acquah's explained that Mr Acquah had become intimidated and upset by Mr Scott wanting to see the original record, and that Mr Acquah had accidentally deleted it from the computer system out of anxiety. From Mr Scott's perspective, there was no way to bottom out the issue.
40. Mr Scott's experience of ECM systems was that a well operated system will provide the ability to schedule calls in a way that's workable for staff, with proper consideration of travel time and rotas. With modern systems, the information can then be sent directly to staff, with staff having the ability to log the times of arrival and departure with either a chip in the service users' documentation (using a smart phone to identify it and log it) or calling a free phone number.
41. At the first relevant inspection, Mr Scott noted that the system had not been set up in a helpful way and he found it very challenging to look through the data and get any clear information. As a result, it was very difficult for him to judge if the system was being run effectively. Mr Acquah was employed, who was employed by the service to provide a quality assurance role for the management of the ECM system. However, after discussion with Mr Acquah, Mr Scott was clear that the system was not being used in the way that it should have been, based on his previous experience with local authorities in contract compliance. By the time of the July 2020 inspection, Mr Scott noted that the system had improved, as he received better documentation from Mr Fawole.
42. By the time of the October 2020 inspection, Mr Scott considered there had been improvements but he was still concerned about the ECM system. October was

a targeted inspection, with no advance notification. He noted that none of the assurances he had been given in July 2020 were in place – he was surprised that he did not see what he had been told he was going to see, which was compounded by the fact that Mr Acquah was not present. On 7 October 2020, Mrs Egunjobi was present at the office but was unable to access the QuikPlan system, despite trying different ways, phoning Mr Acquah’s number on a number of occasions (he was working from home) and speaking with the helpline. She did not seem to know that the ECM system had not been working for the previous three days. She did mention that the service was looking to change to a new ECM system provider. From Mr Scott’s perspective, this was the fourth consecutive time he had visited the service and it was still not managing its ECM system adequately, despite the reduction in the number of service users. From his perspective, it seemed as if no one was aware that the system had not been working properly for three days.

43. Mr Scott had concerns with Mr Fawole’s position – that Ms Goncalves was going to be able to turn the service around and drive the necessary improvements and now that she is no longer present at work, he was indicating that Mrs Egunjobi was the person who can turn the service around. Mr Scott’s view was that the service had made clear improvements since the inspection of July 2019, but he considered that other areas had not improved or new issues had been identified at later inspections.
44. Ms Reed attended the July 2019 inspection on day two and the targeted inspection of October 2020. She attended on day two of the 2019 inspection as Mr Scott and Ms Appah were having so much difficulty reconciling the data they had been provided by the service. Ms Reed attended in October 2020 due to the impact of Covid-19 and capacity in her team. She confirmed that after each inspection, there was a management review meeting, which included the head of inspection and a member of the CQC’s legal team. After each inspection, the decision remained to continue with cancellation of registration as a proportionate response. In her experience, a fall in service users usually leads to services having additional capacity for improvements to be accelerated, not least as there are fewer service users for which records must be updated and reviewed and fewer staff members to supervise. She saw it as a correlation between the downscaling of capacity and speed with which a service addresses concerns.
45. Ms Reed recognised that there had been improvements with the service, but nearly 18 months since the first relevant inspection of July 2019, there were still serious concerns with the service. In her experience, it takes a service approximately 12 months to demonstrate significant improvements. For Ms Reed, it was of particular concern that Regulation 17 remained an issue, as without effective oversight, governance, systems and process, in effect, the infrastructure in place – it makes it very difficult to see how other improvements will be sustained and continued. In her experience, there is often a significant improvement with the involvement of consultants and there is often enough time for a service to be brought into compliance. As far as Ms Reed was concerned, any system is only as good as the oversight being provided. In October 2020, Ms Reed observed a system which was fully reliant on Mr Acquah, who did not

notify Mrs Egunjobi that there were issues with the ECM system. Ms Reed also indicated that at no point did Mrs Egunjobi state that there was a migration between the ECM systems. As far as Ms Reed was concerned, Mrs Egunjobi was not aware of missing data, which was why Ms Reed set it out in her email of 7 October 2020. She cited her experience of assisting with improving services and noted that an effective system of governance should not be reliant on one individual – it's about the processes, check and audits embedded to ensure that other people can pick up the oversight so services users can remain safe.

46. Mr Fawole gave oral evidence which demonstrated his commitment, over many years, to caring for people who require support – a passion which is closely aligned with his faith and work at his church. From his perspective, he was clear throughout his evidence that he took full responsibility for the failures of the service, at their most serious during the July 2019 inspection. He fully accepted and registered his regret at the incident of March 2019 which led to a service user having lasting kidney damage. Mr Fawole explained that even before the inspection of July 2019, he could see that the rate of missed visits was increasing, as was the number of complaints from service users. In fact, he started having concerns in around September 2018 and decided to put together a business improvement plan, which was in the hearing bundle. Mr Fawole accepted that the service has struggled over the past couple of years and it was not the service he wants to build. He understood that the CQC wished him to be more involved in delivering a better service and getting things right. He accepted that there had been systemic issues with regards to safeguarding and QA processes and that in the past, any improvements made had not been sustained. He also accepted that there had been a continuous breach of Regulation 17 and that was quite concerning as he acknowledged that he needed to work with the CQC and agreed completely with the need for effective leadership.
47. He considered that the service is improving – progress has been made since July 2019. This point was the crux of Mr Fawole's appeal – due to the rate and nature of progress of improvements made since July 2019, it is disproportionate to cancel the registration of the service.
48. Mr Fawole acknowledged that the service had grown too quickly by the point of July 2019. At that time, there was a team of 12 staff members in the office to meet the needs of approximately 130 service users, along with approximately 115 to 120 staff members in the field working on zero-hour contracts, with mixed availability due to commitments with other care agencies. He employed Ms Goncalves as the new registered manager based on her previous experience and engaged the service of BRKCC as external consultants, which included Mr Acquah, in an effort to ensure a steady rate of progress, understanding that a significant culture shift was necessary. Ms Goncalves developed an action plan, with the external consultants working to ensure completion and then the team would agree on the RAG rating once the actions were deemed complete. Mr Fawole observed that the reduction in numbers was difficult on morale and there was some resistance to the culture shift. In late 2018, Mr Acquah was hired by the service as a care manager for the services users based in Lambeth

London Borough Council. He first left the service in February 2019 as Mr Fawole was not satisfied with his work. Mr Acquah was advising that tasks had been completed and RAG ratings could be moved to green, when the tasks had not actually been completed. Mr Fawole also noted that other care managers had issues with Mr Acquah, so Mr Fawole asked him to leave the service. Mr Acquah resigned at that point as it appeared that he was delegating tasks and not ensuring that they had been completed. Mr Fawole, at that point, had concerns about Mr Acquah's competency in care management and managing a team of people. By the time of January 2020, Mr Fawole employed Mr Acquah in the role of ECM manager on the basis that it was management of a system, a system for which he had good skills, rather than management of people and care.

49. Mr Fawole was clearly disappointed with the inspection of October 2020 and Mr Acquah's lack of involvement by not engaging in the process and providing crucial information to Mrs Egunjobi. Mr Fawole accepted that the way in which he managed Mr Acquah was a failure of leadership and Mr Acquah's employment came to an end for a second time on 7 October. Mrs Egunjobi and Mr Fawole now oversee the ECM system. For Mr Fawole, he accepted that at times he was too close to staff, including managers, which meant that he had not always detached himself and put in place tougher requirements. He used the example of staff informing him that they had done things and he would believe they had, but he did not check if they had and he knew that was something he had to ensure. He advised that he has learnt a lesson from this and wished to demonstrate that he can lead in a better way in the future. Mr Fawole's current routine is to wake up each morning between 6 and 7am and carry out a check of the ECM system (now nurse buddy) on his laptop, noting his tasks for the day on a list on his smart phone.
50. Mr Fawole was very disappointed that the service received seven breaches in the January 2020 inspection. After that inspection, the service changed its focus to the areas which were in breach, bringing in a second consultancy service, called 'Hello Care'. The pandemic made the provision of care quite difficult and Mr Fawole felt that the workload was increasing even though the overall package of care was smaller. However, he felt satisfied with the level of staff meetings taking place in the office or via Zoom two to three times a week, as well as constant communication over WhatsApp with the carer staff. By the time of the July 2020 inspection, the ECM system was projecting real time data onto the wall in the office, in an effort to ensure the service was as responsive as possible to issues, as they arose.
51. By the time of July 2020, Ms Goncalves had indicated to Mr Fawole that she was struggling so he made the decision to recruit Mrs Egunjobi to assist as there were further breaches from that inspection and a need to allocate tasks to staff to ensure improvement. By the time of the October 2020 inspection, the service had decided to move to a new ECM system – nurse buddy – to meet the needs of the ten service users (8 for personal care and 2 for non-personal care) remaining at the service. Mr Fawole indicated that the ideal number of service users would be 20 to 30, taking into consideration the processes now in place. Mr Fawole considered that the service has now addressed the cultural

issues and the communication which is now in place is completely different – with everyone working to continuously improve. His longer-term plan was for the service to take on one new service user each week, checking that the provision of care was working.

52. Mr Fawole explained that at the moment, he is involved in conducting spot checks and audits, along with Mrs Egunjobi – he is looking for consistency and performs his review role once a month. He has been reviewing the care plans since July 2020. He accepted that there had been no audits of the audits - a quality assurance framework, but as of July 2020, that is now in place. Ms Goncalves remains on sickness absence – since 6 or 7 August 2020 and since that time, Mrs Egunjobi has been in the role of acting manager, with support from Mr Fawole. In retrospect, Mr Fawole felt that he had put too much trust in Ms Goncalves and too much responsibility on her, accepting Ms Appah's description of the dysfunctional nature of the working relationships she observed during the inspections of January and July 2020. Mr Fawole indicated that he had learnt a lesson from that and agreed that there had been a failure in leadership over a period of time.

53. Mrs Egunjobi started her role with Sonia Heway in June 2020; she was interviewed by Mr Fawole only, but reporting to Ms Goncalves. At the time when Mrs Egunjobi started, Ms Goncalves was in the manager role, supported by Hello Care external consultants. BRKCC are now longer used by Sonia Heway. Mrs Egunjobi noted that every decision had to go through Ms Goncalves, with Mrs Egunjobi focusing, in particular, on staffing and recruitment processes, as well as risk assessment and management. Mrs Egunjobi got the sense that Mrs Goncalves was overwhelmed before she went on sickness absence, as she wished to review every change to a document and would not permit other staff to save documents on the shared drives. At the moment, Mrs Egunjobi is completing an application for registration as the manager of Sonia Heway with the CQC, but if Ms Goncalves returns to work, Mrs Egunjobi is committed to working with her, noting that Ms Goncalves is also focused on driving improvements.

54. She stated that the system which is now in place is mitigating past errors, noting that there have not been any medication errors since July 2020 and pointing to the system of supervision which is now in place to support carers with required behaviours and expectations with the use of spot checks. In fact, on the morning of 7 October 2020, Mrs Egunjobi was planning to complete a series of spot checks, but events were overtaken by the unannounced inspection from Ms Reed and Mr Scott. Mrs Egunjobi found the process really stressful – she couldn't make contact with Mr Acquah as her voice calls were going to voicemail, her computer system had a virus, she could not access the QuikPlan system and she felt panicked and intimidated by the presence of Mr Scott, who was sitting next to Mrs Egunjobi and wanted to see the information, to the extent that when Mrs Egunjobi called QuikPlan for assistance, Mr Scott wished to speak with them. Mrs Egunjobi perceived Mr Scott as being aggressive during the inspection of 7 October as he stood behind her at the desk.

55. From Mrs Egunjobi's perspective, she has observed Mr Fawole as a dedicated

and supportive boss who is willing to do what it takes to bring the service to the standard required by the CQC, citing the example of moving from QuikPlan to Nurse Buddy. In terms of Regulation 17 (good governance), she is of the view that the service is in a good place, improving further after the unannounced inspection of 7 and 9 October 2020.

The Tribunal's conclusions with reasons

56. Due to the number of allegations dealt with below, we have appended them to this decision in a chart form.
57. We found Ms Appah, Mr Scott and Ms Reed's oral evidence to be credible and found that their evidence was supported throughout by the documentation. They applied the process they were required to follow in their roles in a professional and diligent manner. We have not accepted the general assertion that they went into the inspections with a fixed view or a pre-judgment of the service. The evidence points to the fact that none of them were decision makers in the process of notifying the service of the intention and eventual decision to cancel the service's registration. Ms Appah, Mr Scott and Ms Reed, in our view, came across as extremely experienced and professional inspectors who conducted their responsibilities meticulously and fairly. Each of them explained that they are not there to catch services out or to attend inspections with fixed views – their roles are to objectively assess what they see, review, are told on the day of the inspection, in the context of the service's regulatory history. We were taken to the decision tree on several occasions during the hearing and accepted the approach – through a series of positive indicators being engaged, the decision tree necessarily placed the decision in the more serious end for the purposes of the ultimate decision maker, the head of inspection.
58. We noted that Mr Fawole, on behalf of the Appellant, had accepted a significant number of the factual allegations in the Scott Schedule and, during the course of the hearing, he accepted a few more. Mr Fawole is proud of his work in the care sector and it was clear to the Tribunal that he takes quality of care seriously, demonstrating a passion about working with people who require care in the community and in their homes; it is a vocation.
59. We considered it of relevance that as each inspection was completed, the Respondent reviewed the continued proportionality of the decision to cancel the registration of the service, noting that if there had been a material change, the appeal would not have made its way to a hearing before the First-tier Tribunal. This clearly goes to our fresh consideration of proportionality, nothing that there have been three inspections since July 2019 and one as recently as the beginning of October 2020.
60. We have found allegation 6 proved. We took into account the evidence of Mr Fawole on this point – he accepted that one of the major issues with improving the service was the culture in place and accepted that carer staff were not always following the requirements being set by managers or coordinators. Mr Fawole also agreed with Ms Appah's observation that the staff were not working

in a functional manner. We also noted the comment from Mrs Egunjobi that some carer staff could be 'cheeky' as she characterised it. We noted that Ms Appah spoke with a coordinator at the time of the inspection in January 2020 and the coordinator informed her that staff made improvement difficult as they were not following the changes being put in place. We found it significant that Mr Fawole also conceded that in the past he had not been robust enough with staff, when they told them they had completed tasks and he later found out they had not. Throughout the oral evidence and the witness statements of Ms Appah, Mr Scott and Ms Reed, the culture amongst the staff was marked out as being of concern until July 2020.

61. We found allegation 9(a) not proved, as we could not conclude, on the balance of probabilities, that the staff had consistently given Lorazepam contrary to medical advice. We accepted as credible the assertion that staff were recording the full name of the tablet they were giving, whilst giving half of the tablet to meet the correct dose. This created a confusing position, but did not convince us, to the requisite standard, that staff were consistently providing the wrong dose.
62. We concluded that the criticism of service user AL's care plan was valid – it was not adequate for care staff working with service user AL to interpret it in a meaningful way. Ms Appah noted that whilst the care plan recorded that AL could become frustrated, there were no details as to the triggers or prompts of the frustration to help carers to manage it. We agreed that without an understanding of the signs of frustration or aggression, the care plan could not be used in a meaningful way by a carer.
63. We concluded that care staff did fail to attend service user AN on 21 January 2020 and, as a result of this failure, lunchtime medication was not administered at the correct time. This seemed to be accepted by the Appellant, and, in any event, the allegation did not require us to consider, as a matter of fact, whether or not the medication was placed in the bin. The documentation provides sufficient evidence to allow us to conclude that the visit did not take place at the appointed time and as a result, the medication was not given at the appointed time.
64. Allegation 12 is found proved. It is accepted that service user AN had an ungradable pressure sore and it is accepted that the service was under an obligation to report the pressure sore to the CQC, irrespective of the steps being taken by the district nursing team or the local authority. We consider that any reasonably informed carer, knowing that they had to use sliding sheets to move the service user, would have known that the service user had a pressure sore. We also considered it significant that Ms Appah was informed by Ms Goncalves, at the inspection in July 2020, that the service was aware of the pressure sore, the concerns about potential inappropriate use of the sliding sheets and the fact that she was waiting for the outcome from the local authority's safeguarding investigation. This leads us to the reasonable conclusion that the service was aware of the issue, but did not seem to be aware of the obligation to report the safeguarding issues to the CQC, irrespective of how it was caused or the outcome of any other investigation.

65. Allegation 15 concerns the lack of adequate record keeping or investigation of complaints raised by service user AE's son. We reviewed the documentation on this issue, noting the concerns from Mr Scott about the lack of information in the complaint log, the passage of time before any form of investigation or response was completed and the adequacy of the notes recorded regarding the remit of the investigation. We accepted the criticisms from Mr Scott on this issue – there was no apparent system in place to ensure that complaints were being identified in a timely manner, triaged/analysed and acted upon. This allegation concerns the adequacy of the response to the complaint and we are satisfied that the response was inadequate on timeliness, the remit of the investigation and exactly how it was closed off. Allegation 17 concerns the adequacy of the investigation of a complaint relating to service user AC. We have reviewed the responses provided by Mrs Ukas to the local authority and have noted that the query from the local authority regarding the ECM system was not dealt with by Mrs Ukas in her response. We have accepted that there was a form of investigation conducted by Mrs Ukas, but we have concluded, on the balance of probabilities, that it was not an adequate one, in that it did not address a key area of concern – the effectiveness of the ECM system in identifying missed visits without the need for someone to raise a complaint.
66. Allegation 20 is found proved. We accept, on the evidence, that the service user changed the time for the visit on 29 March 2019, but even with the time change, the carer still attended later and the service user was left without food and fluids for a delayed period of time.
67. Allegation 21 concerns the way in which the ECM system was being managed to ensure that late and missed visits were being monitored and escalated appropriately. Mr Scott provided comprehensive evidence about the extent of the issues with the ECM system. Not only did we hear evidence about the difficulties in monitoring this system to the extent that it was being projected onto the wall by the time of the July 2020 inspection as an acknowledgement that it needed to be used in a more effective, real time manner, we heard evidence that on each inspection, the system was not being used effectively as a tool of oversight. Mr Scott provided oral evidence, cross referenced with records from the ECM system, to demonstrate that on a significant number of occasions, staff arrival and departure times for visits were being recorded manually due to apparent issues with the remote technology being used to log the times during visits. Irrespective of what was going on with the movement from one ECM system to another, by the time of the October 2020 visit, it was apparent that for three days, no system of monitoring of visits was operating and Mrs Egunjobi was not aware of this issue – receiving no meaningful assistance from Mr Acquah, as acknowledged by his removal from post immediately after the inspection. This was plainly a significant issue, not only for the reason that local authorities require an adequate system to be in place, but from a risk management perspective – there was simply no way to monitor if visits were actually being conducted at their appointed times. By this stage, Sonia Heway had received a number of inspection reports which detailed ongoing concerns, not only with level of oversight, but with the effectiveness of the systems in place to manage risk and ensure, at a basic level, that visits

were being completed and missed or late visits were being identified and acted upon with contingency arrangements. We were not satisfied that the ECM system was being used and managed in a way which allowed for data integrity- we know this as any attempt at cross referencing the times at which visits were due to take place, as noted in service users' records, with the system's data, led to discrepancies – to such an extent that after the first day of the inspection of July 2019, Mr Scott had cause to discuss the issues with Ms Reed and engage her attendance for day two.

68. From reviewing the documentation, it is not clear what action was taken in relation to the negative feedback from service users L, BC and BD – as no records exist to indicate how the feedback was acted upon. As such, allegation 25 is found proved.
69. Allegation 26 concerns the date on which the supervision record was created. We have accepted the explanation, as a reliable one, that the document had been exported in some form on the date in question to a PDF format, hence why it was shown as having been created on that date. We do not consider that sufficient evidence has been presented to allow us to conclude, as more probable than not, that the supervision record had been created in its entirety on the day in question. Therefore, this allegation is not proved.
70. Allegation 28 concerns the failure to resolve a complaint raised by service user AS's relative concerning the conduct of a carer and missed visits. On the records presented, we accept that there was an intention to visit the relative to speak with him directly about the issues, but there is no record of how the complaint was resolved. Therefore, we found this allegation proved.
71. Allegations 38, 44 and 45 are not proved, it was accepted during the oral evidence, by Ms Reed and Mr Scott, that there had been improvements in the areas of staff recruitment, adequacy of training for staff and the integrity of the training establishment in place. As such, we do not accept, as a matter of fact, that there has been sufficient evidence presented to allow us to conclude that these areas of concern led to ongoing breaches due to a lack of sufficient progress. We accepted the evidence from Ms Reed – that there was no specific breach of any regulation caused by the way in which Mr Fawole offered training to his staff. She stated that it is often good practice to have training provided by an independent, third party organisation. However, there was no criticism of the way in which the Greenwich School of Health and Social Care provided training to staff or the quality of the training.
72. We have found allegation 49 proved. We considered the evidence as to the management structure at each inspection up to and including July 2020. We noted the organisation chart presented by Mr Fawole in the hearing bundle, understanding that this was historical and represented an aspirational picture of the structure. We found it concerning to note that by the time of January 2020, there was a team of external consultants in place, working with Ms Goncalves, noting the evidence of Ms Appah as to the lack of a functional structure. July 2020 seemed, on the evidence, a more confusing picture. Ms Goncalves continued to be the registered manager of the service, but Mr

Fawole proceeded to interview and select Mrs Egunjobi to work with and report to Ms Goncalves. By this stage, a different team of external consultants was involved in assisting to improve the service. We heard considerable oral evidence from Mr Fawole on his involvement, at various points, with an acknowledgement that he considered he needed to be more 'hands on' with the service, but this did not accord with his view that Ms Goncalves would be the right person to 'drive improvements'. It was unclear as to the nature of the professional relationship and levels of accountability between Mr Fawole and Ms Goncalves – this was borne out in the evidence of Mr Fawole himself, in which he acknowledged, in both his approach to managing Ms Goncalves and, seemingly, Mr Acquah, he relied too heavily on what he was being told, without verifying the information for himself with a review of the systems or the documents in place. We noted that it is only as a result of the outcome of the inspection of July 2020 that Mr Fawole made a decision to begin directly auditing records and documentation once a month. We also took into account the evidence of Ms Appah and Ms Reed on this point – that by the time of the reduction in the number of service users (to ten as of October 2020) and the extent of the issues which formed the breaches of the Regulations in July 2019, January 2020 and July 2020, it should have been an absolute priority for Mr Fawole, as the nominated individual, to know the key information about the service users and with reassurance that all documentation was in place and correct. We considered that this evidence supports the conclusion that the structure and lines of accountability were simply not clear since the inspection of July 2019.

73. Allegation 40 was accepted by Mr Fawole during the course of the hearing.

74. We have found allegation 50 proved with regard to Ms Goncalves' understanding of the safeguarding obligations of the registered manager to the CQC. Ms Appah provided oral evidence that Ms Goncalves did not appear to understand the obligation to report any safeguarding incident to the CQC without waiting on the outcome of any other investigation.

75. We considered Mrs Egunjobi to be a credible witness who aimed to assist the Tribunal in her oral evidence. She demonstrated a real commitment to providing good standards of care – this much we know from her response to a previous caring role she undertook. However, by the time of her recruitment in June 2020, we noted that she was not recruited to be the registered manager of the service in its current form. We have concluded that we do not have sufficient evidence presented to allow us to conclude that it is more probably than not that Mrs Egunjobi does not have the capability to drive improvements to the service. We simply cannot reach a safe conclusion on this allegation and as such, we must find it not proved.

76. Allegation 52 is found proved. Inspections are based on what is observed and noted on the day of the inspection. It is not in dispute that on the day of the inspection in July 2020, the service did not have the correct, updated Covid-19 guidance in place in order to manage the risk of infection. Practice by the carers may well have been correct – we cannot reach a conclusion on that point and we have not been asked to do so. We also accept that after the inspection,

Sonia Heway ensured that the guidance was corrected and updated – a step which Ms Appah and Mr Scott would expect as a reasonable response to the concerns raised – but the issue is that it was not correct at the time of the inspection. For that reason, we must find this allegation proved.

77. The same rationale applies to allegations 53 and 54, noting that 54 was accepted by Mr Fawole during the course of the hearing, in any event.
78. Allegation 57 is found proved – the information was requested on the day and could not be provided to Ms Reed – of particular importance given the historical issues with this service user’s pressure sore, something Ms Reed was aware of, in conjunction with Ms Appah, and as a matter of logic, by this point in the inspection process and with the reduced number of service users, Sonia Heway should have ensured access to this information for Mrs Egunjobi.
79. Allegation 58 is found proved. We did not accept the proposition that the carers should be led by the service user as to the calculation of the risk of falls relating to poor vision.
80. Allegation 60 is found proved. We have accepted the evidence of Mr Scott that the Covid-19 policy was not complete, in that it asserted that there was a business continuity plan and checklist in place to ensure preparedness for the pandemic, but Ms Goncalves was not aware of those documents. We consider it more likely than not that if the documents existed, Ms Goncalves would have been aware of them, given her understanding of Covid-19 processes and the work she carried out to ensure the inspectors received an updated policy after the inspection in July 2020.
81. Allegation 62 is found proved. We accepted the oral evidence of Ms Reed on this point – the fact of a festive period does not provide a reasonable excuse for there to be gaps in the provision of care to service users.
82. Finally, allegation 63 is found proved, following the same rationale for allegation 57.
83. Finally, Mrs Egunjobi provide evidence that she perceived Mr Scott to be aggressive at 7 October 2020 inspection, based on his manner in dealing with the ECM system difficulties and the lack of physical distance in place between Mr Scott and Mrs Egunjobi. We heard from Mr Scott and Ms Reed on this issue. Ms Reed was present throughout, in the same room, apart from when she left for comfort breaks. We asked Mrs Egunjobi if she had raised her concerns about Mr Scott’s manner at the time in question, whether informally with Mr Fawole, or formally with the CQC. Mrs Egunjobi stated that she had not. We had an opportunity to observe Mr Scott as he gave evidence to the Tribunal. We took into account the evidence of Mr Scott and Ms Reed, that social distancing was observed during the October 2020 inspection. Mr Scott accepted that he was focused on trying to ascertain the information he needed as part of his inspection – an issue he dealt with throughout all four inspections as it was difficult to receive the information in a timely manner, with the obvious finite nature of any inspection. We are not satisfied, on the evidence presented,

that Mr Scott was aggressive on 7 October 2020. We noted that Mrs Egunjobi was feeling really pressured on the day, having been let down by her colleague and with persistent system issues. We have concluded that it is more likely than not that on the day in question Mr Scott was not acting aggressively and Mrs Egunjobi was mistaken in her perception of his behaviour, not least as she was under pressure on the day, pressure which was coming, at least in part from questions and request from Mr Scott in the reasonable fulfilment of his role.

84. The Tribunal reminded itself that we are looking at matters afresh. We do that by taking into account all of the evidence in the hearing bundle, the supplementary documentary evidence and the oral evidence provided during the hearing, as well as applying the requirements in sections 3, 4 and 17 of the 2008 Act and the 2014 Regulations. We have paid regard to the Enforcement Policy (February 2015) and the Enforcement Decision Tree document (January 2017) which sets out the principles applied by the Respondent in decisions of this kind. We have considered at all times the principle of proportionality, which we must consider, amongst other factors, pursuant to section 4 of the 2008 Act.
85. We have also borne in mind Sonia Heway's regulatory history, noting that it has never achieved an overall rating that sits above 'requires improvement'. We could not ignore the fact that the service has been in consistent breach of Regulation 17 (good governance) since the inspection from 2016, noting that for the purposes of this decision, we are concerned with the outcomes of the inspections of July 2019, January 2020, July 2020 and October 2020, where at each inspection, the service was found to be in breach of Regulation 17. Regulation 17 sets out the fundamental requirements of good governance which broadly cover the ability of the registered person (in this case, Mr Fawole) to access, monitor, improve, mitigate and constantly evaluate and improve the quality of services, risks and practices of the service. We consider that compliance with this regulation is fundamental to protection and promotion of the health, safety and welfare of people who need domiciliary care.
86. We took into account that the timescale for improvement has been considerable. The service has now had almost 18 months to demonstrate sustained improvement from the time of the notice of proposal being issued. We noted the evidence of Ms Reed, in particular, on this point, that ordinarily, the CQC expects to see the notice of decision to cancel registration as the urgent prompt to ensure that substantial improvement is made and sustained over a period of approximately 12 months. In this case, we have significant concerns that the service has not been able to demonstrate embedded improvements to such an extent that it was found to have no breaches on the subsequent inspections which have taken place, in particular by the time of the inspections of July 2020 and October 2020. We noted the evidence provided that demonstrated the commitment to improvement – the evidence is important, not only in demonstrating commitment, but also in assisting the Tribunal to assess the sustainability of the improvements. One of the key difficulties the Tribunal faced was that clear documentation, setting out a 3/6/12/24-month strategy for improvement, with, for example, a quality assurance programme, an updated risk register, a longer term plan for recruitment, training and

performance management of staff, just as examples of documents we would have wished to see – they were not present in the hearing bundle. We asked Mr Fawole about his plans for the future on how to tackle the urgent improvements required, which he accepted needed to take place. He was able to inform us that the service would look to take on one new service user per week and then assess how the service was managing their needs and he advised us of his daily routine of making ‘to do’ lists for the day, as well as his recent steps towards completing monthly audits, all against a back drop of 10 services users. We concluded that this fell far short of sufficient evidence to persuade us that Sonia Heway had now turned a corner and is in a position to make or sustain improvement to the service to such an extent that it will no longer be in breach of the 2008 Regulations and no longer poses a risk to service users who requires the services it offers as a regulated activity.

87. One area, in particular, which most effectively encapsulated the ongoing concerns in relation to good governance came from the oral evidence of Mr Fawole with regards to Mr Acquah. A member of staff who was effectively dismissed from his role as a care manager for not being able to successfully deliver the requirements of the role through risk management and people management, was brought back, at a crucial point in the service’s delivery of care, after a second critical inspection report in January 2020. Mr Acquah then proceeded, on the evidence of Mr Fawole and Mrs Egunjobi, to let the service down to such an extent that Mrs Egunjobi could not provide the required and basic management information to the inspectors in October 2020. This, to the Tribunal, is a clear example of a failure of good governance. We could not understand the decision to re-employ Mr Acquah and assign him such a crucial area of responsibility, which ended up having serious consequences for the service during the inspection of October 2020. This was poor judgment which is a clear example of ineffective leadership – an attribute which is essential to good governance. A further significant point arises in that we have concluded that Mrs Egunjobi was not aware that the ECM system was down and had not been working properly for three days. This was a substantial failure in governance and oversight, which directly contributed to the decision to find Sonia Heway in breach of Regulation 17 for the fourth time in approximately 15 months. We concluded that Mr Fawole, despite various efforts to change the ECM system, to change the way in which it was monitored and to change the personnel involved in managing the system, did not seem to grasp the fundamental point that an ECM system of this kind required a clear process for operation and monitoring at all levels in the staff, which once embedded, would mean that any member of staff could review it and rely on the integrity of the data and escalate issues as they arose. We have concluded that even by October 2020, the service was not able to demonstrate that this was being completed effectively. We accept that Mr Fawole is committed to the role and responsibilities of a carer, but we do not accept that he has been able to manage and lead this service effectively.

88. We have considered carefully the decision of the Respondent in October 2019. We have concluded, without hesitation, that at the time when the decision was made, it represented a proportionate decision. However, our role does not end there, we are required to consider the developments since the point of the

decision, which include the three inspections undertaken in January, July and October 2020 and their outcomes, as well as the numerous steps undertaken by Sonia Heway to improve, embed improvement and demonstrate mitigation of risk to such an extent that repeated breaches are highly unlikely as of the date of decision and moving forward. The Tribunal has considered all of the material extremely carefully, applying the principle of proportionality and it has concluded that the decision to cancel the registration of Sonia Heway Care Agency Limited to provide a regulated activity remains a proportionate decision which meets the requirements of section 4 of the 2008 Act.

Decision

The appeal is dismissed.

The Respondent's decision of 22 October 2019 to cancel the registration of Sonia Heway Care Agency Limited is confirmed.

Judge S Brownlee

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

Date issued: 7 January 2021