Care Standards Tribunal

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

Heard at the Southend Magistrates Court on 27, 28 and 29 October 2015

Before

John Burrow **Tribunal Judge**
Sue Last **Specialist member**
Marilyn Adolphe **Specialist Member**

BETWEEN:

Mr and Mrs Dorval

Appellants

-v-

Care Quality Commission

Respondent

[2015] 2433.EA (linked to 2432.EA)

DECISION

1. Mrs and Mrs Dorval appealed the decision of the Care Quality Commission (CQC) to cancel the registration of Lystra Dorval as registered manager and the registration of Jos Dorval and Lystra Dorval together as registered providers in respect of Brookfield Residential Home in Clacton-on-Sea. The notices of decision are dated 23rd April 2015 and 22nd April 2015 respectively.

2. Mrs Dorval appeared at the hearing and was assisted by Ms Ramdin her niece who had legal training in Trinidad, although she was not qualified or admitted in this country. Mrs Dorval was supported by her son Daniel Dorval. Mr Jos Dorval did not appear, but Mrs Dorval as joint provider gave evidence on his behalf, with his agreement.

3. The CQC were represented by Mr Rush of counsel. He called Ray Finney, Gaynor Chamberlain and Julie Small, who are Inspectors with the CQC. He also called Joanna Govett as CQC Inspection Manager and Peter Tempest, Director for Integrated Commissioning (North) with the Essex County Council (The Local Authority or LA).

4. The original bundle ran to some 767 pages. Additional bundles were served by both parties and incorporated into the main bundle resulting in some1030 pages. Further pages were served during the course of the hearing.

5. An order was made under rule 26 of the 2008 Rules that the hearing was to be in private. This was because intimate and possibly distressing details of service user's medical conditions and aspects of their care were likely to be canvassed during the hearing and the service user's names were likely to be referred to in the hearing.

6. An order was made under rule 14 of the 2008 Rules that no matter likely to lead members of the public to identify any service user or a family member of a service user was to be disclosed or published. The names of service users have been anonymised in this decision. The names of the appellants have not been anonymised as this was felt not to be in the interests of justice.

Background

7. Mrs Lystra Dorval has been manager and provider of care services at Brookfield for many years. The Health and Social Care Act 2008 made provision for a new regime of registration and regulation of care homes, and on 1st October 2010 Mr and Mrs Dorval registered as the providers of the regulated activity "accommodation for persons requiring nursing and personal care", for a maximum of 11 people residing at Brookfield. Mrs Dorval further registered as the manager of Brookfield.

The CQC case

8. Brookfield was visited by CQC inspectors on 24th August 2011, and it was found to be non-compliant with Regulations 9,12,13,14,16 and 21. These breaches constituted a major concern and compliance actions were set. A follow up inspection carried out on 1st February 2012 found that improvements had been put in place to meet the regulations except for Reg.10 which remained in breach. The level of concern was lowered from major to moderate.

9. A further inspection was carried out by the CQC on the 4th May 2012, when non-compliance was found in respect of Regulations 9 and 10. These were classed as a moderate concern. A further inspection on 20th September 2012 found compliance with Regulations 9 and 10. On 30th March 2013, anonymous concerns were received by way of the CQC website. An inspection was carried out a few days later on 5th April 2013, when the home was found to be compliant.

10. On 19th August 2014 a concern by the son of service user H was communicated to Essex County Council. Brookfield had contracted with the County Council for the placement of residents at the home and the Council retained inter alia Safeguarding responsibilities for service users (SUs) placed under the contract. The concerns notified by the son concerned a request by Mrs Dorval for £3000 for toiletry items, a sum which was initially paid by the service user H, but later demanded back by the son. The Essex County Council (LA) raised a safeguarding alert (SGA) and determined that under the terms of the contract with the home, the SU must be advised of such charges at the point of placement, and this had not been done. Further the sums demanded were uniform amounts and no receipts were provided. The LA concluded Mrs. Dorval was not safeguarding the SU's finances effectively. These concerns were fed back to Mrs. Dorval.

11. On 28th August 2014, two further SGAs were raised by the LA concerning the finances and the care of service user E. The first concerned the fact the SU was billed £1340 for toiletries by Mrs Dorval. There was no audit trail, accounting record or proof of purchase. The daughter of the SU was requested to pay cash within 48 hours but she refused and contacted the LA safeguarding unit. Again the LA concluded Mrs Dorval was not safeguarding the finances of SU's effectively. The concerns were fed back to Mrs Dorval.

12. The second SGA on 28th August 2014 was issued during the annual review of service user E's care. It was found by LA staff there were no risk assessments in place concerning the using and handling of SUs, the use of hoists or pressure area care. The care plan did not reflect the care and support needed by the SU. Further although Complan (a dietary supplement) had been prescribed on 2nd July 2012, it did not appear on the MAR sheets. Further there was concern E had been moved to a shared room, despite records suggesting she had remained in her own room, without prior consultation with the LA contracts team or the SU's family.

13. On the 5th September 2014 the premises were inspected by the CQC. Breaches of regulations 9, 10, 12, 13, 18 and 22 were found. Concerns included inadequate care plans which had no evidence of mental capacity documentation and no mention of the SU's best interests decisions. There was a lack of risk assessments, unclean equipment and premises, inadequate medication procedures, inadequate staffing levels and staff training and lack of review and monitoring systems. On 11th September 2014 these concerns were discussed by phone with Mrs Dorval. On 17 September 2014 a Warning Notice was issued in respect of the breaches of regulation 9, with compliance to be by 28th October 2014. Compliance Actions were taken in respect of Regulations 18,12,13,22 and 10.

14. On 9th September 2014 an SGA was raised concerning the covert medication of service user C. In an SGA dated 29th July 2014 Mrs. Dorval had been requested to stop this practice with immediate effect until appropriate guidance and authorisation had been sought. On 9th September 2014 a further SGA was raised by the LA concerning the use of a lap strap restricting movement of service user B. Both SGA's were raised in response to concerns that the Sus were at significant risk of harm. AS a result on 11th September 2014 the LA suspended all new placements at the home.

15. On 12th September 2014 the North East Clinical Commissioning Group (CCG) carried out a medication administration and handling audit at Brookfield. The home was found to be non-compliant in a number of areas including no full written medicine policy procedure, no adequate system to ensure accuracy on the MAR sheets (considered a serious risk), some inaccurate or incomplete MAR sheets, no PRN protocols, no record of returned medication, no procedure to check the accuracy of prescriptions before they are dispensed, no regular medications audits, and inadequate staff training. The audit found serious concerns and concluded that people were at risk of inappropriate handling and administration of medicine. Medication audit tools, protocols and records were provided to Mrs Dorval to assist her to become compliant.

16. On 18th September 2014 the Environmental Health Officer visited the premises and served an improvement notice in relation to the lack of a legionella assessment, and the absence of a hand rail on a stair. The Food Hygiene rating was downgraded from 5 to 1 (major improvement necessary). An EHO inspection on 29th October 2014 indicated the improvements had been made.

17. On 19th September a further SGA was raised in respect of service user E. Staff were seen moving E by means of two rigid boards and straps. Although the SU remained calm the practice is out of date and should not be used and placed E at serious risk of harm. There was no entry in the care plan, no risk assessment, no planning and no recommendation from the O.T about moving the patient, and therefore any care administered to E was not planned. The concern was referred back to Mrs. Dorval for immediate action.

18. On 19th September the Contracts Team from the LA formally advised Mr and Mrs Dorval that they were in breach of their contract with the LA concerning placement of SUs at Brookfield, and that a failure to remedy the breaches may result in termination of the contract.

19. On 2nd October 2014 the CCG again inspected the medication administration and handling. While some improvements had been made by the home, including a written medications policy, a medication flow chart, a weekly audit and a medication returns

book, the improvements consistently lacked detail or were not robust enough, demonstrating that the staff did not understand what the policy meant in practice. Further a number of improvements had not been made, including a lack of PRN protocols, and inaccurate and inadequate MAR sheets. The CCG concluded despite providing support, the home had not put in place appropriate arrangements to ensure people were protected from the risk of unsafe practices in relation to the handling and administration of medicines.

20. On 9th October 2014 Mrs Dorval submitted an action plan which set out the actions taken to achieve compliance with Regulations 18,12,13,22 and 10.

21. On 18th October 2014, the LA visited the home and service user C complained that the staff had roughly handle her despite her telling them she was in too much pain to walk. She said staff had roughly pulled her causing a lump on her wrist and causing pain to her feet, legs and groin area. An SGA was raised in response to a concern of physical abuse, which was communicated to Mrs Dorval.

22. On 18th October 2014, a further SGA was raised concerning service use H, in response to concerns of neglect. Concerns included an unlocked cupboard with sharps inside, lack of checks on staff, and SU call bells not being connected. In respect of H, who had a grade III pressure sore, there was no record she was being turned regularly. Drinks in her room had been left out of reach. Services user C appeared dehydrated, with her drinks out of reach. Not all SU's had fluid charts. There were concerns about statutory medications procedures. Mrs Dorval showed she did not understand the needs of the Sus in her care who were frail and at risk. The medication concerns were discussed with Mrs Dorval who said they were awaiting advice from the pharmacist.

23. On 22nd October 2014 an SGA was raised concerning neglect in respect of service user H who was receiving end of life care. There was no end of life care plan, and DNR was not in the care plan. The SU did not receive fluids or food during the visit.

24. On 5th November 2014, the LA reviewed the SGAs and visits to the home over the past 6 weeks which had required improvements, but concluded adequate improvements had not been made. The LA expressed grave concerns about the extremely poor standards of care that the SUs were receiving, and they terminated the contracts with Brookfield on 10th November 2014. Notification was given that all residents were to be found alternative placements. On 10th November 2014 the LA were so concerned to ensure the safety of SUs that external support staff were commissioned to support the staff in the home so that the Sus care , treatment and safeguards were met.

25. On12th November 2014 a further SGA was raised by the LA concerning service use B in response to concerns of physical abuse. Whimpering and crying was heard from the dining room, where two of the staff were using an under arm drag lift on B (which is banned). The SU was incontinent of urine. Mrs Dorval was in the lounge but denied seeing the manoeuvre.

26. On 12 November 2014, another SGA was raised in respect of service user B in response to concerns of physical abuse and neglect. She was seen to be strapped into her chair, moaning and groaning. She had a black eye. Feeding was inadequate and no liquid was seen to given. The bed was seen to be a divan type bed, which did not facilitate the use of the hoist. Her shin and foot were oozing liquid which quickly soaked the sheets. Her incontinence pad which was soaking wet was removed. On removal a smell of dying flesh was apparent. A large open ulcer, giving sight down to the bone, was visible on her left buttock. It was about 4 cm in diameter with a black ring around the top edge. This was a grade 3 ulcer, which could develop into grade 4.

27. When faeces were cleaned from her bottom a developing ulcer could be seen on her right buttock. The staff said they knew about the ulcer and told Mrs Dorval about it. When asked, Mrs Dorval said it was just a little black spot and it would get better. She said she had not yet called the district nurse. She was asked to call the district nurse immediately, but it seems this was not done. Staff contacted a district nurse later, and B was admitted to hospital with a suspected broken nose and ulcerated bottom. She was found to have bruising up and down her arms and legs.

28. On 13th November 2014 a further SGA was raised in respect of service use B in relation to possible physical and emotional abuse. Records held at the home suggested no district nurse had visited B since 2011. There was no record of how bruising to face and body had occurred, although a body map dated 26th October 2014 stated briefly the patient had head butted a carer. There was no entry in the accident log, it was not recorded in the risk assessment and there was no care plan in place to assess and follow up the SU care and treatment. B appeared in pain. The MAR sheet was inaccurately completed, with no reference to an allergy for penicillin.

29. On 13th November 2014, the premises were again inspected CQC. The purpose of the inspection was threefold - to see if the warning notice in respect of breaches of regulation 9 found during the inspection on 5th September had been remedied, to see if the improvement notices in respect of regulations 18, 12, 13, 22, and 10 had been met, and to assess the general level of care. During the inspection Mrs Dorval claimed that the warning and improvement notices had been complied with and that a good standard of care was being provided. However the inspectors found this was not the

case and that even the most basic level of care was not being provided.

30. The warning notice of the 17 September 2014 had not been complied with and Regulation 9 was continuing to be breached. Further breaches were found in respect of Regulations 13, 10, 22, 11, 17, 15, and 16. Regulation 18 was now compliant. An inadequate rating was given in all categories, including safety, effectiveness and caring. Concerns included staffing levels, poor medicine management, staff training, risk assessments, nutrition and liquids, lack of individual choice, poor guidance to staff in care, particularly end of life care. SUs were not protected from unsafe or inappropriate care. SUs were not referred appropriately to health professionals. The routines, systems and regimes in place resulted in poor standards of care to adults at risk. Quality assurance systems had not been implemented and proactive managerial oversight to ensure risks to people's safety and welfare were not being identified.

31. Mrs. Chamberlain and Mrs Perry were the CQC inspectors who attended the home on the 13th November. Along with a health care professional, Mrs Chamberlain found service user E with a grade 4 pressure ulcer on her right ankle, a grade 1 pressure ulcer on the inside of her sacrum and a grade 3-4 pressure ulcer on her left buttock. On the advice of a health care professional service user E was taken to hospital, where the ulcers were confirmed by the hospital clinical staff. In respect of service user B Mrs Chamberlain and the health care professional found a grade 3 pressure ulcer with thick black necrotic tissue, which could escalate to a grade 4.

32. Mrs. Chamberlain found the risk of developing ulcers had not been reviewed and preventative measures and reporting safeguards had not been taken. The care plan for service user B had not been updated since 2009. She found the care plans and assessments for B were inadequate in several respects. She found moving and handling practices and documentation was inadequate in several respects. End of life care was inadequate with no clear planning and inaccurate documentation, such as the fluids chart. Management of medication and staffing remained deficient in several respects, while quality assurance was a concern, as were safeguarding, respecting Sus and poor standards of care. On 14 November 2014 all remaining SUs were removed from Brookfield.

33. In the CQC inspection report for the 13 November 2015 it was said that the inspectors had looked to see if the action plan provided by Mrs Dorval had been implemented. However Inspectors had found a number of breaches to the Regulations and the provider had not responded effectively or promptly to the CQC concerns. Very little improvement had been made. There was serious risk of harm because care was not being assessed and delivered to meet SU's

changing needs, and the care provided was not person centred to safeguard the SUs and act in their best interests. Staff numbers were insufficient, particularly at night. There was poor management of medicines and people were not always receiving the medication as prescribed. Staff did not have the knowledge, skills and support they needed to provide care and they did not always recognise poor practise. SUs were not supported to have adequate nutrition and drink and care was based on routines rather than individual choice. SUs were not protected from unsafe or inappropriate care.

34. Professional were concerned about the ability of Mrs Dorval to identify improvements, take action to assess them and sustain them. She did not acknowledge the concerns of the CQC and others, and had not taken the opportunity to learn from concerns and take appropriate action. The home did not engage positively with people who raised concerns to find a way forward for resolution. There were no systems in place to monitor the safety and quality of the service provided.

35. Mr. Tempest is the Director for Integrated Commissioning with Essex County Council. He was the LA officer who authorised the decision to terminate Brookfield's contract. In his evidence to the Tribunal he said there had been some 30 visits to Brookfield by the LA since June 2014. Brookfield had been monitored by the Serious Concerns Group, Quality Assurance and Safeguarding divisions of the LA for some time. Mr. Tempest said the matter was referred to him on 8th November 2014. He was aware of the Action Plan produced by Ms Dorval. He explained that when conditions at a residential home were so serious that they were referred to him, he was not looking at individual instances of concern, but at the patterns of difficulties and clear evidence of attempts to achieve compliance. The LA will expect remedial efforts to be disseminated among all staff, and this was not happening at Brookfield.

36. Mr Tempest said the LA will provide advice and a framework for action, but it's not for the LA to continue to chase Mrs Dorval. The LA's action in suspending new placements at Brookfield on 11 September 2014 was clear evidence to the manager of the LA's concerns, and the need to take remedial action. Mr. Tempest said the LA had given a reasonable period for compliance. 12 SGAs were issued before the SUs were finally removed from Brookfield on 14 November 2014.

37. Mr Tempest said at a meeting of LA departments involved with Brookfield, all 11 senior officers advised him the situation there was so serious it was now irremediable. The case for closure which included issues with pressure area sores, staffing, medication, environment and dignity of service users was overwhelming. It was necessary to draft in support staff to facilitate transfer of the Sus. Because the situation was so serious and irremediable it was felt a

meeting with Mrs Dorval was inappropriate.

38. Mr Tempest said the reports from the residential homes the SUs had been moved to, along with reports from the hospital about SUs who had been taken there, confirmed poor care at Brookfield. Mrs Dorval had not indicated to the LA that she could not meet the needs of SUs at Brookfield. Nurses may have been visiting Brookfield, but it remained the duty of care by the home to prevent noncompliance. Pressure sores are preventable with good care, and it is not sufficient to rely on treatment. Mr Tempest said the LA was looking for compliance and any competent provider would rectify compliance issues at an early stage. He said the contract with Brookfield was clear and transparent that the requirement for compliance was permanent and ongoing and not just at visits.

39. Joanna Govett, Inspections Manager at the CQC reiterated that even if Community Nurses were visiting Brookfield, the duty of care still rests with the provider and manager. The duty includes a duty to work with health care professionals and others, but the duty to provide appropriate care ultimately remains with Mrs Dorval.

40. Mrs Govett confirmed the Police completed their investigations in April 2015, and while they had not found sufficient evidence to prosecute, a number of concerns remained, including neglect, financial irregularities and the leadership at Brookfield. Mrs Dorval could have retrieved any documentation (including care plans) taken by the police, as early as April 2015, when the investigation was completed. In any event the police would have taken only copies of the documentation.

<u>The case for Mr and Mrs Dorval</u>

41. Mrs Dorval, Ms Ramdin and Daniel Dorval refused to attend the third day of the hearing. Mrs Dorval sent an email on the morning of the third day, which although somewhat ambiguous, appeared to suggest she was suffering from physical and emotional stress. However there was no medical certificate and no application for an adjournment. We had the opportunity to observe her over the two days of the hearing and she seemed sharp and quick with very good grasp of the details of the case and an ability to ask pertinent questions of the witnesses with no appearance of stress. We did not accept her health either prevented her from giving evidence or warranted an adjournment.

42. Her email, on one reading, might have been interpreted as suggesting the tribunal was biased and had already made its mind up. We considered this issue. We noted the many times we had assisted her during the course of the two days of the hearing to clarify her case so we could understand it and so it could be put to witnesses. We had permitted an opening speech by Ms Ramdin in

order to assist in our understanding of her case. We had done what we reasonable could to facilitate the appearance of her witness Shani King, Deputy Manager of Brookfield, who had claimed she was too ill to attend. There was no medical certificate for Mrs King, but never the less we facilitated a video link, but Ms King declined this. Then we facilitated a phone link, but at the time of the email indicating Mrs Dorval was not attending, it was still unclear if Mrs King would agree to give evidence by phone.

43. We assisted Mrs Dorval throughout by allowing late documentary evidence to be adduced. We allowed the presence of Daniel Dorval to assist Mrs Dorval. We issued an order requested by Mrs Dorval to obtain evidence of nursing visits to the home. We ruled that anonymous complaints should not be taken as evidence of the truth of their contents. We concluded we had not been biased, had not pre-decided the issues, but rather had taken all reasonable steps to understand Mrs Dorval's case and to facilitate a fair hearing in respect of it.

44. In general terms we were satisfied that Mrs Dorval could have a fair hearing, despite her decision to refuse to attend the third day. Because of our efforts to clarify her case, we now had a good understanding of it. There were two very full witness statements from her in the bundle, along with documentary evidence.

45. For all these reasons and bearing in mind there had been no application for an adjournment, we decided, bearing in mind the overriding principle in rule 2 of the 2008 Rules to deal with cases fairly and justly, to continue with the case in Mrs Dorval's absence. We did not draw any adverse inference from Mrs Dorval's absence, although her absence inevitably meant that her evidence in her witness statements was not on oath and had not been tested in cross-examination.

46. Mrs Dorval's general defence was that Mrs Chamberlain had been involved in a safeguarding matter at Brookfield some 8 years earlier during which she had invented concerns about the home which she was later unable to substantiate. Because of this she was alleged to be biased against Brookfield and had either exaggerated or invented the matters contained in the inspection report of 13th November 2014. It was suggested that this in turn had prejudiced the LA against Mrs Dorval because the LA later refused to meet Mrs Dorval to discuss improvements. It was suggested by Mrs Dorval that the matters Mrs Chamberlain had invented or exaggerated included the use of divan beds at the home, the extent of service user E's ulcers, the fact SU's didn't get appropriate care, the absence of care plans, staff training and the anonymous complaints on 30th March 2013.

47. In respect of the earlier matter some years previously, Mrs

Chamberlain said she had little recollection of it. Mrs Chamberlain was not the lead inspector and the matter was an SGA concerning primarily the LA. Mrs Dorval could produce nothing to support her suggestion that allegations had been invented by Mrs Chamberlain, and Mrs Chamberlain strongly denied any bias towards her or inventing any of the concerns she had recorded during the inspection on 13th November 2014.

48. In respect of the ulcers found on services user E, said by Mrs Dorval to be exaggerated by Mrs Chamberlain, she pointed to the fact the independent documentation by the hospital confirmed the number and seriousness of the ulcers. In respect of the use of divan beds she pointed to the corroboration in the SGA of 13th November 2014, drawn up independently by the LA inspector. In respect of general poor care she pointed to the significant amount of independent evidence from the LA, from the receiving care homes and the hospital confirming the poor condition of the SU's.

49. In respect of the care plans, which Mrs Dorval claimed had been taken by the police, Mrs Chamberlain pointed out only copies would be taken by the police and documentation could have been retrieved by Mrs Dorval once the police investigation ended in April 2015. In respect of the anonymous complaints the CQC had received via the CQC website, Mrs Chamberlain had had nothing to do with their recording and only became aware of them in 2014 when she drafted the minutes of the management meeting on 13th November 2014.

50. Mrs Dorval suggested the hospital had told her they intended to raise the SGA on 13th November 2013 in respect of the District Nurse who had visited E. However the SGA document showed it was in fact raised in respect of Mrs Dorval, but Mrs Dorval claimed this was only because of information provided by Mrs Chamberlain. However the independent SGA document shows clearly the factual basis on which it was raised, which was all about the seriousness of the ulcers, and not about information provided by Mrs Chamberlain.

51. Mrs Dorval claimed Mrs Chamberlain had understated the number of working hoists and slings at Brookfield, but the information was supported in the SGA documentation and by statements by the staff. Mrs Dorval suggested end of life care was in place and being provided to service users E and H. Mrs Chamberlain said the care plan did not adequately provide for pain relief, monthly care, adequate nutrition and liquids. Further some of the fluid charts were inaccurate, as was demonstrated during the hearing. Mrs Dorval said the daughter of service user E was content with the end of life care and the SU should not go to hospital. Mrs Chamberlain said the daughter was not aware of how ill the SU was. An earlier letter from Dr Ralphs cautioned against hospital referrals for patient E, but this had been superseded by events and the seriousness of

her condition.

52. Mrs Dorval suggested Mrs Chamberlain had exaggerated the concerns relating to medication, but they were supported by the two CCG audits. Mrs Chamberlain denied saying she was going to put in her report that nothing had been done at the home, regardless of the reality of the situation. Mrs Chamberlain said she had merely told Mrs Dorval the warning notice had not been complied with. Mrs Chamberlain stressed that the LA inspections prior to 13th November 2014 had been carried out by the LA staff independently from her and the LA had already concluded that Mrs Dorval was not making the necessary improvements.

53. In her witness statements and in the letter from her solicitors dated 20th April 2015, Mrs Dorval repeated a number of the allegations she had made against Mrs Chamberlain. She suggested the CQC had deliberately added a page to the warning notice of 17th September 2014, but when it was shown the Warning Notice containing the extra page had only been produced in December 2014, Mrs Dorval abandoned the allegation. In her witness statement of 20th April 2015, she again complained about Mrs Chamberlain. Mrs Dorval put forward explanations of financial irregularities with respect to patient toiletries, which did not in fact absolve her from all the criticisms made in respect of this matter. She claimed risk assessments and care plans were in place, although inspections by LA and CQC did not find them and they were not produced to the inspectors by Mrs Dorval.

54. Mrs Dorval claimed services user E received visits from District Nursing Staff. She sought an order from the Tribunal for nursing records which were obtained and did show attendance and treatment of 3 ulcers on E by district nurses. However the documentation from the hospital indicated additional pressure sores which do not appear to have been treated. There was other documentation confirming treatment including from Dr Tien. However the records did not explain why the ulcers were allowed to develop in the first place.

55. In respect of the staff numbers Mrs Dorval said there were sufficient staff although these assertions were contradicted by observations made by the Inspectors who visited the premises. Similarly with respect to usable hoists and slings at the premises, she has challenged the accuracy of some of the SGAs. She claims equipment was kept clean, although this was contradicted by the Inspectors. She claims the medication and the MAR sheets were accurate and complete although this is contradicted by two audits by the CCG, by the LA inspectors and by the CQC inspectors.

56. Mrs Dorval claimed Brookfield was effectively compelled to accept service user C on her discharge from hospital. She claimed service

user B was not constrained by her lap strap and Brookfield was not in breach of DOLS in respect of it. She claimed B's care was fully set out in a care plan, although this plan has not been produced by her in support. Mrs Dorval claimed not to be aware of B's ulcers, until 13th November although staff said she had been told earlier.

57. She claimed she had issued action plans to the CQC and the LA, and that all matters had been complied with. The CQC action plan produced by Mrs Dorval referred to regulations 18, 12, 13, 22, and 10. The LA action plan produced by Mrs Dorval included references to quality assurance, staff, users' finances, nutrition and hydration, moving and handling medication, fire safety, CRB, DOLS and cleanliness. There is little detail in the CQC action plan and implementation appears limited. There was a long list of defects found by the LA and the CQC after the action plans were issued. Mrs Dorval claimed a staff member at Brookfield had been given a warning for removing documentation. She accused an LA inspector of bias.

58. Mrs Dorval claimed the police had no concerns about Brookfield following their investigation despite the list of concerns explained by Mrs Govett. It was claimed Bonnie Green, social worker confirmed the improvements made by Mrs Dorval in a letter but these were suggested improvements described by Mrs Dorval not necessarily those seen by Mrs Green. A number of other allegations were raised by Mrs Dorval but by her refusal to appear on day 3 of the hearing none were given on oath or subjected to cross examination. In general her allegations were not supported by documentation where this was available.

59. Mrs Shani King's statement was challenged by the CQC and again no evidence was given by her on oath. Much of her statement was simply a reiteration of points made by Mrs Dorval, and these have been dealt with above. Mrs Dorval included two CQC Reviews of Compliance documents dated October 2011 and April 2012. Both these documents include the mention of regulations which were still not very complied with. An inspection report of April 2013 indicates standards were then being met.

60. An LA quality improvement document exhibited by Mrs Dorval indicates on 2 June 2014 some standards were being met; although it appears some had not been. A letter from Ranworth Surgery by a nurse practitioner dated 30th July 2014 indicated medication could be administered covertly although this practice was later criticised. Quality assurance visits in early November 2014 appeared to suggest some improvements had been made, but these were contradicted by SGAs and CQC inspections. There were some references from the families of SUs, speaking well of Brookfield, but there was little to indicate they knew the full extent of the failures at the home.

Consideration by the Tribunal

61. We considered the written and oral evidence in the case. We noted there were two appeals, one by Mrs Dorval as manager of Brookfields and one by Mr and Mrs Dorval as providers of services at the home, and that we should consider our decision in respect of each, although much of the evidence will be relevant for both. We reminded ourselves that the CQC had cancelled the registrations under Section17 of the Health and Social Care Act 2008 on the grounds that regulated activity was being carried out which was not in compliance with the relevant regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These included regulations relating to quality of care, medication, suitability of equipment, cleanliness, consent, respecting service users and staffing.

62. We bore in mind that our powers on appeal were contained in Section 32 of the 2008 Act, and that we may confirm the decision of the CQC, direct that it cease to have effect or impose discretionary conditions. The appeal is a rehearing of the case and we step into the shoes of the CQC and remake the decision. The appeal is not a review of the CQC decision and post decision evidence is admissible. The burden of showing regulated activity is being carried on in breach of the regulations is on the CQC on the balance of probabilities. The decision must be necessary and proportionate.

63. We accepted that early concerns in 2011 and 2012 – some of them major - had been remedied after follow up by the CQC. However it appeared Mrs Dorval could not maintain the improvement, because compliance again appeared to be failing in 2014.

64. We considered whether the breaches of the regulations found during the CQC inspection on 5th September 2014 had been made out on the evidence. A significant proportion of them were effectively admitted by Mrs Dorval since she did not challenge them. Rather she submitted action plans with the intention of remedying the breaches of the regulations. Furthermore many of the breaches were supported by the SGAs issued by the LA during this period. We found the breaches on 5th September 2014 proved.

65. We considered the breaches of the Regulations found by the CQC inspectors on the 13 November 2014. We concluded on the evidence that none of the allegations of impropriety against Mrs Chamberlain made by Mrs Dorval were true. We did not accept that Mrs Chamberlain's findings at Brookfield on 13 November 2014 were exaggerated or invented. This was because her findings were supported by the documentation in the bundle, by the evidence of Ray Finney, and by the evidence of the LA inspections and the

SGA's. We concluded Mrs Chamberlain had carried out a difficult inspection on the 13th November 2014 in a detailed and accurate manner. We found her to be an excellent witness – truthful and reliable.

66. Evidence of breaches of the Regulations on the 13 November 2014 were further supported by independent documentation such as the reports from the hospital. We accepted that all the breaches of regulations 9, 10, 11, 13, 15, 16 and 22 reported in respect of the 13 November 2014 inspection by the CQC had been made out on the evidence.

67. We considered whether the decision to cancel the registrations was necessary and proportionate. We noted Mrs Dorval had submitted action plans to the LA and the CQC on 9 October 2014. We accepted the evidence of Mr Tempest and the CQC that Mrs Dorval must have been put fully on notice of the need for timely and substantial improvements. Further we accepted that Mrs Dorval was given adequate time to make improvements. However we also noted the evidence of Mr Tempest and the CQC inspectors that very little of the action plans had been implemented. The fact SGAs were still being issued by the LA in October and November 2014, the fact the CCG still had concerns about medication, and the fact the CQC found so many breaches of the regulations in the inspection on 13 November 2014, all support the case that wholly inadequate progress had been made by the home.

68. We accepted the findings in the inspection report of the 13 November 2015 that Mr and Mrs Dorval had not shown insight, had not shown a commitment or ability to drive change and did not display the managerial ability to bring about the necessary improvements. This is the case for their roles as manager and providers at Brookfield. We concluded the CQC decisions to cancel the registrations were necessary, proportionate and correct.

Decision

The appeals against the CQC decisions to cancel the registrations as manager and provider are dismissed.

Judge John Burrow
Tribunal Judge Care Standards
First-tier Tribunal Health Education and Social Care Chamber

Date Issued:11 November 2015