Care Standards

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

The Tribunal sat over 7 days on 25, 26, 27, 28, 29 September 2017 and 2 and 3 October 2017 at the Royal Courts of Justice, London
Deliberation 9 October 2017

BEFORE
Ms Melanie Lewis-Tribunal Judge
Ms Marilyn Adolphe -Specialist Member
Ms Pat McLoughlin -Specialist Member

BETWEEN:
Ebonycare Limited

Appellant

v

Ofsted

Respondent

[2017] 2916.EY

FINAL DECISION

Representation

The Appellant appeared in person. .

The Respondent was represented by Mr Reed Solicitor Advocate.

Witnesses:

We heard oral evidence from the following witnesses:

Respondent

1. Matthieu Pooley: Social Worker LB Hammersmith and Fulham
2. Stephanie Clements: Commissioner RB Kensington & Chelsea
3. Angus Mackay: Ofsted Inspector

4. Lee Kirwin: Ofsted Inspector
5. Jacqueline Graves: Ofsted Inspector
6. Patrick Sullivan: Ofsted Inspection Manager
7. Ike Onwubuya: Social Worker LB Waltham Forest
8. Dawn Haughton: Local Authority Designated Officer - LADO
9. Carolyn Adcock: Ofsted Senior Inspector. Lead Decision-maker

And read the evidence of:

10. Kenneth Smith: Ofsted Inspector
11. Sandra Jacobs-Walls: Ofsted Inspector
12. Sharon Payne: Ofsted Inspector
13. Kevin Whatley: Ofsted Inspector
14. Dr Rebecca Packer: Consultant Psychologist
15. Simon Slater: Ofsted compliance and investigatory team
16. Nicholas McMullen: Ofsted Senior Inspector.

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Appellant

1. Kevin Cadogan: Registered Individual Ebonycare Ltd
2. Colin MacDonald: Registered Manager (not signed statement did not attend)
3. Sonia Lowe Manager (not signed statement and did not attend)

Reporting order

1. There shall be a Restricted Reporting Order under Rule 14(1)(b) of the Tribunal Procedure Rules (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 ('the 2008 Rules') prohibiting the publication (including by electronic means) in a written publication available to the public, or the inclusion in a relevant programme for reception in England and Wales, of any matter likely to lead members of the public to identify any child or their family member mentioned in the appeal.

2. For that reason we have deliberately neutralised the way in which we refer to certain events in this decision.

The Appeal

3. These are six joint appeals, brought against Ofsted's decision to cancel the registration of all of the six children's homes operated by the Appellant company, namely: –

1. Ebony House
2. Satchmo House
3. Rural Way
4. Tubman House
5. George Washington Williams House

6. Maya Angelou House

4. The sole owner /director of the company is Kevin Cadogan, whose late mother and father started Ebonycare thirty years ago. Ofsted acknowledged that Ebonycare was set up in particular to meet the gap in provision for the care and support of African-Caribbean children within the care system, in the south London area. The then business model worked and had delivered valuable care in the past. On the death of Mrs Cadogan, her son Kevin took over the overall management of the company and it is Ofsted's case that since then there has been a significant and consistent decline in the level of compliance with regulations. It is Ofsted's primary concern that this pattern of failure placed children at risk such that the Appellant was unable to protect or promote the welfare of children.

5. All six Children's homes are effectively closed, as they are all subject to Statutory Restriction Notices preventing the homes from accepting any new referrals. None of them have any children placed there who had been resident prior to the imposition of those notices. In the case of Tubman House and Satchmo House those Notices have been in effect continuously since 20 September 2015 and 6 January 2016. The other four homes, been subject to Restriction Notices since 28 June 2017. The Appellant has not sought to appeal any of the Restriction notices, save in respect of those upon Tubman and Satchmo House which were withdrawn.

6. Notices of proposal to cancel the registrations were served on 26 September 2016. Representations to Ofsted were made by the Appellant Company, represented by a lawyer and Ofsted decided to proceed to Cancellation. The notices were served on 12 December 2016. The appeal notices were lodged on 12 and 13 January 2017.

7. The basis of Ofsted's decision is that the combination of :-

a) The failure to respond and act on the outcomes of various inspections and compliance notices over the years, and
b) the recent denial of access to Ofsted of entry to the homes, and
c) the nature and approach of Kevin Cadogan, as the Responsible Individual who was the controlling person behind the Appellant Company, and who failed to address these issues.

Their conclusion was that there was, and is, no realistic prospect of the provider consistently meeting the statutory regulations and hence it is been necessary to proceed to Cancellation as a last resort.

8. The Appellant Company disputes this. It disputes the accuracy of Ofsted's findings and does not accept breaches of the Regulations. It alleges that Ofsted's findings were prompted by a grievance allegedly held by an ex member of staff, against Ebonycare, who had been in dispute with the Appellant company many years previously, and/or by institutional racism. The company could only provide staff ratios that Local Authorities who commissioned their services were prepared to pay for, against public funding

cuts. In the final analysis Mr Cadogan conceded that a few mistakes were made but nothing that would require Ebonycare Ltd to be closed down. He asked, even at this late stage, for a further opportunity to put things right by appointing consultants to work with Ofsted to run a few of the homes and gradually build them back up.

The Setting:

9. Each of the six children's homes is in a domestic house in South London, all within the same approximate geographical area. It is common ground that the children placed there had complex needs and required a particularly high level of safeguarding, many were subject to care orders and many had a history of behavioural problems, offending, substance misuse and aggression. They were often placed as the lone child in the setting due to their vulnerability and the risks they posed to themselves and the community.

10. For the avoidance of any doubt the Post 16 settings and 'after-care' provision operated by the Appellant are not subject to regulation and are not part of this appeal.

Procedural Issues:

11. This case has a long history and raised a large number of applications to submit late evidence by Mr Cadogan. They are set out in some detail because they are relevant to the issues in the case.

12. On 14 September 2017, the Judge sitting alone heard an application to strike out those parts of the Scott Schedule to which the Appellant simply put Ofsted to proof and offered no evidence. The Notices of Proposal to cancel registration were served on 26 September 2016. A Representations hearing was held which the Appellant attended but Ofsted proceeded to cancellation. The notices were served on 12 December 2016. Ofsted's primary evidence was served on 21 and 23 March 2017. The Appellant's evidence was originally due on 19 April 2017 but none was received and no explanation was forthcoming. At that point Mr Cadogan instructed Mr Gledhill specialist counsel under the 'direct access scheme' whereby he had to prepare the documentation but would be represented at the hearings. A deadline of 30 May 2017 and another of 19 June 2017 were missed. At a Telephone Case Management Hearing on 30 June 2017, at the suggestion of the Appellant's own counsel an 'unless order' was made. The Appellant's evidence was to be served by 17 July 2017, failing which the appeals were to be struck out. A number of explanations had been offered, in particular medical reasons for which there was no evidence, and some technical difficulties. On 14 September 2017 parts of the appeal were struck out, because of persistent non-compliance. To do otherwise would be to accept the tribunal orders had no effect. The Tribunal refused an application for an adjournment to instruct representation, because the Appellant had had ample opportunity over many months to instruct a representative and make funds available.

13. On Sunday 24 September 2017 and only because the tribunal

administration was working overtime, the Tribunal had notice of an application for an adjournment from Mr Rajiv Menon QC, who had no previous dealings with the case. It is common ground that there is voluminous evidence in the case and Mr Menon was clear that he would need at least a week to consider the papers and a short adjournment was not an option due to the volume of the case. We learnt that Mr Gledhill (of whom no criticism is made) had given Mr Cadogan until 20 September 2017 to make arrangements for payment but in fact withdrew his representation on 18 September 2017. Mr Menon acknowledged that the case would need a 'root and branch review', so effectively to start again.

14. The Tribunal refused the application. We applied the overriding objectives set out in Rule Two Tribunal Procedure Rules, to deal with cases justly and proportionately. It had already ruled against an adjournment to instruct representation on 14 September 2017 when the Appellant said he would represent himself if he had to. There had been a delay in receiving the documents from Mr Gledhill, but in accordance with the tribunal procedure all documents had been sent to him as the named representative. We further had regard to the reasons that part of the appeal was struck out, namely persistent non-compliance. The Tribunal and Ofsted had adopted a flexible approach but Mr Cadogan had not complied. Ofsted has been put to considerable expense by many hours of time-consuming preparation, increased as the case they had to prove, was not clear. The case was ready to proceed. The panel had in accordance with its usual practice carefully read six bundles of evidence. The issues in the case were familiar to them and applying their specialist knowledge and experience of litigants in person, they could ask questions to ensure a fair and transparent hearing.

15. The application to adjourn having been refused Mr Menon QC withdrew representation. We allowed him to have the afternoon of the first day in order to assist Mr Cadogan. The solicitors helpfully released two interns who acted as note takers for Mr Cadogan.

16. By the order dated 14 September 2017, the Tribunal had allowed Mr Cadogan to submit an additional hundred pages of evidence. (Ofsted suggested 20 pages), with a direction that the Appellant should indicate the nature and purpose of each piece of evidence. This did not happen. On 18 September 2017 he submitted one hundred pages, however the majority of the pages contained multiple pages of originals, so condensing four pages on to one sheet, as a consequence they were illegible. Additionally the Appellant served a fifth statement, going over historic matters. He also submitted a signed statement from the mother of a child at the home which also didn't relate to events arising since 1 March 2017. Mr Reed set out his objections in a note dated 19 September 2017. In short, the way this evidence had been submitted was totally unsatisfactory and in contravention of both the spirit and the letter of the Tribunal's Order. We agreed. Overnight, Mr Reed examined the documents and we agreed to admit an email from a Fire Service Officer although it was of limited value because it referred to an appointment, not that an assessment that was actually carried out. We also agreed to admit a risk assessment by Chubb.

17. On day two, 26 September 2017, a further application was made, without prior notice, to admit a recording made on the Appellants mobile phone/dictaphone. The test for evidence is relevance. We refused the application. We stressed on this and at a number of other occasions during the hearing that the Appellant had been given numerous opportunities to comply with Tribunal deadlines and submit evidence. It was not clear which Ofsted inspection this related to; it was a covert recording; there was no transcript and it was unfair to Ofsted to admit it at this late stage.

18. On Day three we did allow Mr Cadogan to submit a trail of email correspondence between Ike Onwubya, social worker from London Borough of Waltham Forest and Mr Cadogan as it was potentially misleading to only look at certain emails. Mr Reed raised no objection.

19. On 14 September 2017 Mr Cadogan had applied for a Witness Summons for Mr Colin McDonald, to attend. It was refused on the grounds that Mr McDonald had submitted a very brief statement of a few lines, which was unsigned. Neither Ofsted, the Tribunal nor indeed Mr Cadogan knew what Mr McDonald would say. There was no confirmation by him whether he would attend without a witness summons. The guidance issued by the Tribunal gives very clear information on what should be in a witness statement. Mr Cadogan repeated the application and it was refused for the same reasons. It transpired Mr Patrick Sullivan had spoken on the telephone to Mr McDonald in an unrelated capacity and stated in oral evidence that Mr McDonald had told him that he now understood what Ofsted's concerns were.

20. Over the weekend we received an Action Plan drafted by a company called Rezume, which Mr Cadogan referred to in his evidence in chief. It was not doubted that he had sought advice from them, however, he said he had not made specific arrangements with them and had not provided funding for this to be put into effect. We declined to admit it.

21. On Monday 2 October 2017 we expected Sonia Lowe to attend to give evidence. Mr Cadogan said he had received an email on the Saturday morning, which it transpired had been sent on Friday 29th September at lunchtime, in response to his request to speak to her over the weekend about her evidence. We asked to see the email. He was in fact part way through giving his evidence at that point and had been warned to speak to nobody about the case. She said she was suffering from a chest infection and high blood pressure and while she wanted to support him but had not understood she would have to attend the hearing. We ruled that we could not place any weight on an unsigned witness statement and that we were not persuaded that either of those conditions for which allowances could have been made would have stopped her attending. We had already clarified that she was living close to or in London.

The Law

22. The legal issues are straightforward. The Decision to Cancel was taken pursuant to section 14(1) (c) of the Care Standards Act 2000 as amended. In essence, these provide that Ofsted as the Registration Authority may, at any time, cancel the registration on the ground that the establishment is, or has at any time, being carried on otherwise and in accordance with the relevant requirements or that the registered person has failed to comply with Compliance Notices served under section 22 A of the same act. Ofsted contends that there was both failure to comply with the relevant Requirements and a failure to comply with the Compliance notices. .

23. The key issues that the Tribunal had to determine in respect of each home was : –

a) Was there a breach of the Relevant Regulation; And
b) If so, is Cancellation of the Registration proportionate step

24. The relevant requirements are principally set out in the Children's Home Regulations 2001 which were in force until 31 March 2015 and partly by the Children Homes (England) Regulations 2015 with effect from 1 April 2015. The 2001 regulations were supported by the National Minimum Standards and the 2015 regulations are supported by the Guide to the Regulations including the Quality Standards, which refer to aspirations not minimum standards.

25. The burden of proof of the breaches of the requirements rests upon Ofsted. The standard of proof is the normal civil standard, i.e. the balance of probabilities.

26. The Tribunal has to consider the situation as it is at the date of the hearing and accordingly should take into account evidence developments/improvement since the original Notices to Cancel were served. Pursuant to section 21 Standards Act 2000 on an appeal, the Tribunal may confirm notice of cancellation or direct that it shall cease to have effect. Additionally the tribunal shall also have the power on an appeal to attach conditions, although in this case restrictions which have not been appealed are in place.

27. Whilst the registration of each home is separate, pursuant to Paragraph 2(7)(b) Disqualification from Caring for Children (England) Regulations 2002 would apply if any or all the registrations were cancelled, as Mr Cadogan would have been a person concerned in the overall management of and having a financial interest in the children's homes, his registration having been cancelled.

28. The only exception would be if a Waiver had been granted by Ofsted. Pursuant to section 65A Children Act 1989, any decision by Ofsted to refuse the grant of a Waiver is subject to right of appeal to this Tribunal.

<u>The key issues / Chronology:</u>

29. The lengthy chronology sets out that over the years a number of issues arose in relation to each the settings. We were assisted by a detailed chronology with a colour key for each home with corresponding page reference, but for clarity we set out the key issues.

30. The key issues were: –

a) Breach of Compliance notices. More than one half of the requirements made in compliance notices are not been met.
b) Failure to provide monthly independent visitors reports as required by regulation 44 (2015 Regulations), previously Regulation 33 (2001 Regulations). Analysis provided by Ofsted: 60% reports not submitted. Recommendations not acted on. Relied on by Ofsted as corroborating evidence of their concerns.
c) Management monitoring reports under regulation 34 (2001 regulations) and regulation 45 (2015 regulations) Very few were received.
d) Failure to evidence training in child protection, first-aid under regulation 28 (2001 regs).
e) Failure to provide access to the homes for Ofsted inspections. The Appellant Company had received more favourable treatment, because appointments had to be made in advance by Ofsted, due to the behaviour of the Appellant, in denying them access to inspect the homes.
f) Failure to undertake, or where taken, poor quality Risk assessments. Also noted by independent visitors. Regulation 12 (2) (b) & 34 (2015 regs).
g) Lone working and risk assessments. This was examined at length and it was agreed that for purposes of the evidence 'lone working' would be defined as where one worker was working alone in a setting with a child without any support from additional staff on the premises. This was distinct from 'one-to-one' working where at least one other member of staff would be present. Regulation 31 (2015), 12 (2) (b) & 34 (2015 regs).
h) adequacy of staffing generally.
i) continuity of staffing.
j) multiple breaches of regulations including recruitment, first-aid qualifications, education, medication, record-keeping: Reg 32(1)(2)(3) (2015). Reg 5 (a)(b), Reg 31 (2015).

These are set out in the Scott Schedule

<u>The Evidence:</u>

31. The Tribunal carefully considered six bundles of documentation, running over 2500 pages. We very carefully considered all the written and oral evidence but we only summarise such evidence as is necessary to explain the Tribunal's position. In the event, in his closing submission Mr Cadogan accepted his failure to promptly act on breaches of compliance but asked for a chance to remedy the situation, before the final step of upholding the Notices

of Cancellations.

32. Given the large volume of issues and documentation we were mindful of the difficulties Mr Cadogan faced as a litigant in person. As such, the Tribunal fully used its inquisitorial powers, took a proactive approach and asked a number of questions. Our role however could only relate to procedural fairness. We had to remind Mr Cadogan on a number of occasions that he was raising issues about which he had not produced any documentary evidence in a setting where it would be expected to have written documents, or on which his case had been struck out. As the evidence will record, we did allow a degree of flexibility, as at points this was the proportionate way to cut through, in particular on email trails

33. Matthieu Pooley is a social worker employed by a London Borough to whom child AC was in care. Mr Pooley described AC as a complex young person. It was common ground that AC was a vulnerable child at risk with very challenging behaviours and had a history of multiple placements, convictions for violent offences, self harming with suicidal ideation, drugs and alcohol. Mr Pooley gave evidence about the timing of notifications of incidents concerning the child to the Local Authority. He told us that having reinvestigated that matter, he conceded that one notification in which AC alleged he had been 'punched in the ribs by a member of staff" had in fact been notified to the Emergency Duty Team of the authority on the same evening as the incident. Mr Pooley felt that whilst the child's basic needs were met, there was insufficient structured work being done with him. The Local Authority had expected that a robust care plan and risk assessment would be put in place to minimise the risk of harm, and support and guide AC to address his substance misuse. His key worker would spend time with him to build a relationship in an effort to engage him in tuition and to alleviate feelings of isolation and create some stability in his life. In terms of therapeutic activities, AC had a keen interest in bikes. Mr Pooley also expected that a bike maintenance course might be set up. Mr Cadogan did not agree. We clarified there was no written evidence of risk assessments, care plans or daily recording in the bundle to show the work that the Appellant stated was being done to give the young person a structured and supervised day, such that he did not keep returning to his home area, which was prohibited by his bail conditions unless he was going to see his social worker.

34. Stephanie Clements commissioned the placement for AC. We learnt that the placement was costing £5,700 per week, as a specialised placement. She accepted that the placement was made in an emergency, in the knowledge that George Washington Williams House had been rated as 'requires improvement' by Ofsted and she had personally carried out a monitoring visit on 31 January 2017. Her evidence echoed the concerns raised by Mr Pooley. AC's placement did not meet the risk assessment and care plan that had been agreed with the Local Authority. He was returning in the early hours of the morning between midnight and 3 am, collected by staff at his request or returned by taxi which was contrary to what was agreed at the LAC planning meeting with the social worker and the Appellant. The daily log was a sparse chronology of AC's movement with no detail of staff time

spent with AC, or attempts and interventions to encourage participation and engagement. She was concerned that the manager was still awaiting a 'Fit Person interview', which Mr Cadogan said had been frustrated by delays caused by Ofsted. Ms Clements said that as a high cost placement they would expect a concomitant level of care to meet AC's complex needs. In the event, the deficit led to the Local Authority to seek an alternative. As a result of what she saw she advised that the three London boroughs for whom she commissioned should not place any more looked after children with Ebonycare Ltd.

35. Jacqueline Graves carried out an interim inspection at Maya Angelou House on 17 March 2014 and judged that it had declined in effectiveness since its last full inspection in May 2013 at which it been judged 'adequate'. Additionally she accompanied Lee Kirwin inspector, on the full inspection of Tubman House on 8 September 2015. He was the Inspector about whom Mr Cadogan had made complaint. As a senior practitioner, she was asked to quality assure Mr Kirwin's performance and she was satisfied about the quality of his work and his performance.

36. Mr Cadogan alleged in a detailed complaint made 9 months later that Ms Graves made racist remarks during her inspection on 17 March 2014. He also raised a number of other issues. He was not present on that date but Mr Colin McDonald the registered manager was on duty. Mr McDonald had submitted an unsigned statement of a few lines alleging that Ms Graves and another person had made racist remarks, saying Ms Graves had queried whether a picture of Haile Selassie was 'appropriate' and that schoolchildren in a photograph Mr Cadogan had taken whilst in Jamaica 'looked haunted'. Given the seriousness of a complaint of racism we spent some time trying to clarify this. Mr Cadogan explained that the art was significant. The project was called Art makes you Smart and was used to stimulate discussion with the children. The details of the incident remained vague as Mr McDonald did not attend to give his own account of what took place at the inspection.

37. The complaint in 2015 concerned a number of issues regarding inspections which took place between 2012 to 2015. In addition to the complaint about Ms Graves it included a complaint that Mr Whatley, Ofsted inspector, on 26 July 2012 had used language that amounted to racism, concerning a member of staff who was from Nigeria. Mr O'Brien, a senior officer from another region of Ofsted, investigated that complaint. On this issue he decided that he had two conflicting account, which he could not resolve and that it was not within his powers to effectively decide which version he preferred.

38. We queried why Mr Cadogan had waited so long to make such a serious complaint, when according to him, Mr McDonald had said the next day 'that it was the worst day of his life' and wanted to resign his post. Mr Cadogan further faced the inevitable difficulties of raising issues months later, when memories had faded. In her evidence Ms Graves denied making any racist remarks. She said she did not recall seeing any pictures and said that if she had done, she would have thought that they were culturally appropriate

and to be encouraged, given the profile of the children in the setting. We did allow in evidence an email from Colin McDonald sent in the days following that inspection to Mr Cadogan, which made brief reference to the reported remarks about the pictures, although no specific reference to racist remarks. It also contained a very long list of works that needed to be done as a result of the inspection.

39. Mr Cadogan's point in relation to criticisms of the conditions in the house was that it was visibly obvious that builders were carrying out major works on the premises and that the home was shut, as there were building materials lying around and piles of wooden flooring waiting to be fitted. So in his opinion Ms Graves should not have raised these breaches of regulations. Ms Graves denied seeing a skip or a quantity of wooden flooring to be laid throughout the home. She said she saw no workers, or vans. We clarified that these refurbishment works did not fall into the category of major structural changes about which the RI would need to notify Ofsted, but queried why, if Mr Cadogan had shut the home temporarily, he did not notify Ofsted. Ofsted did not accept that the home had been shut because the child in residence had only left in unexpected circumstances the week before, so it was not accepted the builder would have been available to start works at that short notice. Additionally Ms Graves said there was nothing to suggest to her that the home had closed and the manager told her it was open to placements.

40. Mr Angus McKay carried out the largest number of inspections at Ebonycare. His main statement was very detailed, cross referenced to reports and ran to some 63 pages and we summarise only key points. He has recently retired. He set out his long experience in childcare, including an OBE for services to young offenders. Whilst in a different professional role he had been aware of and spoke positively of work of the late Mrs Cadogan, providing culturally appropriate care for Black Ethnic Minority children. He commenced inspecting Ebonycare's homes in May 2012. He was the lead inspector of 18 full inspections, 13 interim inspections, 12 monitoring visits and 9 fit Persons interviews. He said that Ebonycare showed a drop in standards across the board. It lacked good managers. They were mostly acting managers, unregistered, as they had not completed the registration process. Many managers appeared capable and some told him that Mr Cadogan micro-managed the service therefore they couldn't develop schemes for effective management and training.

41. Mr Cadogan wished to introduce evidence about a paedophile infiltrating Orchard Lodge, where Mr McKay had a senior role. This was late evidence and we ruled that it was not relevant in as it happened in any event before Mr Mackay came into post. Mr Cadogan mentioned a former member of Ebonycare staff who worked for Ofsted Mr Mackay denied talking to her about the case. She had been in dispute with Ebonycare through protracted litigation 20 years ago. Again we ruled that was not relevant.

42. Mr McKay visited Maya Angelou House following the 'inadequate 'judgement of the inspection conducted by Jacqueline Graves. He said that no comments were made to him about racist remarks, the only issue that was

raised with him was Ofsted being unfair. He noted improvements. Mr Cadogan had told him that the fire authority had completed a fire risk assessment and that he commenced work to address all identified actions in the Chubb report. It transpired that an appointment was to be made by the fire officer to visit the premises but no record of a fire assessment was produced. Considerable time was spent on this issue. Mr Mackay was concerned at the serious breach of Regulation 31 (1) and 1(a) (2001) i.e. failed to supply evidence of consultation with the Fire Authority and take adequate precautions against the risk of fire. The home's Statement of Purpose identified a window as an escape route, despite it having bars on it. He attempted to clarify this with the fire service who said that windows could never be an escape route. By the time of the interim report on 4 September 2014 the bars and grilles on the windows had been removed, but there was still no suitable current fire risk assessment.

43. Mr Mackay conducted a fit Person interview for Olivia Bush on 18 December 2014 for which we read the notes. He recommended Ms Bush be registered as a manager of one children's home Ebony House. In his opinion Ms Bush made some insightful comments about the staff lacking formal training. Ofsted thought that Ms Bush could be a "powerful force" in Ebonycare. Patrick Sullivan agreed a temporary arrangement with Mr Cadogan allowing her to manage the two adjacent children's homes.

44. Mr Cadogan's case was that Ofsted had frustrated registration of his managers, in particular Sonia Lowe whom he employed from Jamaica. As the rules for employment checks differ overseas Ms Lowe could not provide an enhanced DBS only a 'Certificate of Good Conduct.' With our leave, Ofsted produced documentation of the history of her application. Ultimately Mr Cadogan accepted that whilst it was returned for technical reasons this was in his view indicative of an obstructive and unhelpful approach. In the past he said the defects would have been pointed out to him in a telephone call, enabling him to correct matters expeditiously.

45. It was the theme of Ofsted's evidence that there were a number of capable managers, but that they were not allowed to manage effectively because of the Appellant's micro-management style which hindered their capacity to develop the service to meet compliance. The daily practice was that managers and staff were spread too thinly across the various settings leading to ineffective service.

46. On 19 June 2014 Mr Mackay conducted a 'fit person' interview with Colin McDonald. The interview recommended Mr McDonald be approved to manage Rural Way, but not also Maya Angelou. Mr McDonald said he was relieved with that decision and that he was happy to focus on one home.

47. Sonia Lowe was appointed as manager of Maya Angelou house on 8th June 2015. Whilst Mr Mackay was concerned that she showed a limited understanding of the then current children's homes regulations and the quality of standards at a full inspection on 21 July 2015, he and Mr Sullivan agreed that a judgement of 'requires improvement' was proportionate given her short

time in the post.

48. Ofsted evidenced 10 notifications of incidents from staff at Maya Angelou House between June 2015 and September 2015. An incident on 30 May 2015 involved Olivia Bush being punched in the stomach by a child DB who then also attacked Mr Cadogan. Mr Mackay had noticed that the child had a good relationship with her and Mr Cadogan. On 10 September 2015, the same young person caused serious injury to Mr Cadogan resulting in a compound fracture to his leg and biting his nose as well as assaulting other staff his mother was also present. The police arrested him and was removed from the home.

49. Mr McKay said he was concerned about notifications that were either late or not sent. One notification was 28 days late. In records he observed a notification had been prepared but not sent despite it being a notifiable incident.

50. Mr Mackay's gave examples of where young people were absent, but was concerned this was not sufficiently particularised or analysed. There were no records available showing how risk was addressed or any cross references to care plans.

51. He was concerned about inadequate risk assessments and gave a number of examples. One child described as vulnerable was admitted with issues of drug use, criminal behaviour and suicidal ideation but the recorded risk assessment stated 'low risk'.

52. Mr Cadogan made a number of points on these individual cases including in the case of the child whose social worker, Mr Onwubuya, gave evidence to the Tribunal. He told the Tribunal that he saw no reason why the child concerned should not have a passport. Mr Cadogan rightly identified the risk of giving him a passport in an email to the Local Authority. However, Mr Cadogan's concerns although well-founded were not transferred into any document that we could see nor found in a risk assessment.

53. We heard about a young person DB who was still in bed at 2 pm, with insufficient attempts to engage in activity or implement the advice of the psychologist. Mr McKay said there was little ability from staff to work with such high need children. For example one child was not attending education sessions that had been arranged for him in the home. The records said he attended three times per week but that was not the case in reality. In his opinion, basic engagement didn't happen. There were some observed positive interactions with children but Mr McKay said "*being nice was not enough".*

54. Initially he believed that they, Ebonycare, worked with Ofsted to improve. They needed a system to manage the homes and undertook to make plans for improvement but in the end these things didn't happen. They regularly had 14 requirements outstanding which were repeated but there was no forward movement.

55. Another area of concern was medication administered by staff. The Independent Visitor had suggested using a MAR sheet to record medication use. The MAR sheet did not tally with the other records of medication. Again, Mr Mackay highlighted some of the difficulties of that, not least because some of the young people were known or suspected to be selling drugs.

56. Mr Mackay felt he had tried to support Ebonycare. In efforts to help Mr Cadogan and his staff raise standards he had made a number of suggestions, including suggesting individuals to carry out independent visits. He gave Mr Cadogan and Mr McDonald his contact details so they could send monitoring notifications to him directly to avoid complaints from Mr Cadogan that there was a conspiracy by Ofsted saying they had not been received. Mr Cadogan did this occasionally but not consistently. Ofsted also gave notice of inspections when they would normally be unannounced so files could be found and produced in time for the inspection. Mr Cadogan gave reasons why he was not happy with some of the names that Mr McKay suggested as Independent Visitors. He said that one person had previously "targeted" Ebonycare. Mr McKay was however clear that he must be independent as an inspector and the choice was ultimately Mr Cadogan's. Overall he, like Mr Kirwin, felt that whilst there were positives within the homes, the inability to bring about positive change was ultimately down to Mr Cadogan. There was inconsistency of care and as the RI he did not have the relevant qualifications to lead and manage his Registered Managers.

57. Mr McKay said he *"was very anxious about recruitment".* There were frequently missing parts of staff files e.g. references. When asked for access to staff files Mr Cadogan chose which files he could view. The regulation is clear that files must be available to view. Extra time was given but Mr Cadogan never fully complied.

58. Mr Lee Kirwin was an Ofsted Inspector, of two years standing; he had 30 years experience working in residential care, probation and social services. He rejected the criticisms of Ofsted which were unspecific. He denied any lack of objectivity, inappropriate comments made when documents were shown, or requiring things to be done in a particular way as "game playing".

59. He conducted a full inspection of Ebony House on 23 and 24 June 2015. The only child in residence was RM. When he went back upon interim inspection on 14 January 2016, RM had been arrested and charged with common assault. He took the view that staff should not be working alone with the young person who was 6'5" tall, who had a history of violence and sexually inappropriate behaviour towards females. Mr Cadogan told him then as he did us this he was unable to provide two to one care as this was down to the Local Authority refusing to fund a two to one placement. At the time Mr Cadogan stated that an assessment would be made which would inform a future risk assessment and identify safe staffing levels. The child's social worker when telephoned refuted Mr Cadogan's account of the professionals meeting. Her view was that they had agreed Mr Cadogan would take responsibility for assessing the risks and determine safe staffing levels to safeguard the child and staff. She agreed that lone working would not be safe

with the young person. Her description of one-to-one meant there would be extra staff allocated, for support. The concern was the multiplicity of staff coming and going in the home. The young person described how he felt "most of them just came to work, showed no affection or love" and felt nobody offered to take him to do activities. He told Mr Kirwin he ate alone, staff didn't eat with him or watch TV. This was borne out in the records showing the allocated key worker had only worked in the home 14 shifts in a seven day shift period. Mr Kirwin raised this with the manager who agreed with his concern. He was concerned that one member of staff who worked several shifts with the young person had only been in post for three weeks and previously been the home's 'handyman'. Mr Cadogan disputed that and stated that the support worker had the necessary training and was working towards a level 3 NVQ qualification.

60. A particular difficulty arose in relation to that inspection. Acknowledging that improvement had been made, Mr Kirwin judged the inspection "requires improvement". That was viewed positively by Miss Bush and Mr Cadogan. As a result of Ofsted's internal processes, the judgement was subsequently changed to 'inadequate', because of the shortfalls in relation to safeguarding and the fact that the provider had still failed to meet a compliance notice. This caused the provider to make a formal complaint to Ofsted.

61. Mr Kirwin undertook a further full inspection of 5 and 6 July 2006. Ms. Bush felt that working with child DB had a better therapeutic outcome by lone working as he could be provoked into aggression if confronted by two members of staff. Mr Cadogan agreed. Dr Packer who had assessed DB did not agree and considered the risks of serious violence to be high. In her opinion this young person needed clear and firm boundaries and more than one staff member would be required to deliver this approach. Mr Kirwin felt that the risks of lone working were poorly understood by Mr Cadogan.

62. Mr Kirwin was also concerned about the numbers of staff that moved between the homes such that there was little staff continuity which impacted adversely on the emotional care of the children. He felt the staff were doing their best but there was no direction or strategy to support the young people in their care.

63. During feedback to Ms. Bush, DB interrupted the meeting and wanted to intervene. Mr Kirwin became concerned that DB had become over-involved in the inspection. Ms Bush had to accompany the Inspector off the premises for his safety. Two Compliance Notices were issued as a result of this inspection, requiring the provider to demonstrate the risks in relation to lone working were managed effectively and the requirements regarding independent visitors were fulfilled.

64. The next full inspection took place on 15 16 September 2015 of Rural Way. Ms. Bush who facilitated the visit was unable to access records and evidence for the inspection.

65. Overall Mr McKay's and Mr Kirwin's view was that staff were well

intentioned, had some of the necessary skills passion and commitment but there simply was no consistent approach to care. They never met as a team.

66. Similar concerns arose on the full inspection at Satchmo House on 22 September 2015. The manager was Mr Martins Yedenu. Here the young person had a history of not engaging with education, but this was not being managed and the information on file was inaccurate. The young person himself commented that staff were inconsistent with him. Again the manager couldn't operate the homes electronic records effectively.

67. On 17 December 2015, there was a further full inspection of Satchmo House conducted by Mr Kirwin with Patrick Sullivan. The Inspection was facilitated by Ms Bush, although she wasn't the manager, who was accompanied by Miss Kathy Walby, who Mr Kirwin knew from a previous employment. Mr Cadogan alleged that there was a conflict of interest because of Mr Kirwin's and Miss Walby's personal relationship. It was discussed and all agreed there was no conflict of interest. If Miss Walby told Mr Cadogan that she had visited his home and knew his wife, Mr Kirwin, in evidence, said this was simply untrue as they had never had any kind of social interaction or personal friendship outside a professional working relationship and he had not been in contact with Miss Walby for over ten years.

68. Mr Kirwin said he also tried to support Ebonycare and felt that there are some well-intentioned staff with a genuine professional commitment, but there was no consistent approach to care. There was no chance for staff to meet or engage in reflective practice or share ideas or the emotional impact of caring for such complex and high needs children.

69. In response to allegations of unfairness Mr Kirwin said it was Ofsted's practice to "triangulate" when gathering evidence from different sources. Inspectors would look to see if evidence fitted together. Inspecting Ebonycare was challenging as written information was sparse and for example rotas did not reflect who was on duty and where.

70. He quoted the example of RM, a Looked After Child who was particularly complex. He was frequently missing, he had disclosed abuse from a previous home, there was no information about his previous placement and he was coming and going at all hours. The logs did not reflect this nor the risks he was exposed to. For example no attempts were recorded about his possible whereabouts when missing.

71. The young person was recorded as having been given a total of £180 over three weeks but there appeared to be no check on how it was spent and his mother reported it was being used to purchase cannabis.

72. Mr Kirwin told us that IT systems were "impenetrable" most of the time. Time was given to provide staffing records but none were forthcoming.

73. Patrick Sullivan had more of an overview. He has been in post as an

Ofsted manager since September 2013. As a Regulatory Inspection Manager, his main role was to provide knowledge, support line management for the inspectors and to take compliance and enforcement decisions. He had personal knowledge of the settings, having conducted an interim inspection of Satchmo House on 25 March, where there was a judgement of 'satisfactory progress' but this was not continued at a full inspection on 13 January 2015 with a judgement of 'inadequate leadership and management' and also on, 30 March 2015. He inspected with Mr Kirwin 17 December 2015 with an overall judgement of 'inadequate'.

74. Mr Sullivan also undertook an interim inspection of Ebony House on 12 March 2014 with a judgement of 'satisfactory progress.' The full inspection of Maya Angelou House on 26 March 2015 had a judgement of 'adequate' overall with leadership and management judged 'inadequate'. He had met with Mr Cadogan on a number of occasions, as early as April 2014. Mr Cadogan said he had employed a new consultant, Dr Lawrence, who had concluded that the current managers were not fit for purpose. Ofsted pointed out that that they had some concerns about the quality of the external monitoring report completed by Dr Lawrence, for example he had said that there was a pleasant garden space, in the home where building work was supposedly taking place. However, as the RI, who Mr Cadogan appointed was a matter for him.

75. It was raised why Mr Cadogan had not focused on management of a few of the homes, bringing them into compliance before moving back up to running six homes again. This had been raised at a meeting on 16 December 2014. Mr Cadogan failed to provide Ofsted with an Action Plan by 5 January 2015 as agreed, or at all. He was also asked for financial information, as he had been asked regularly before but he only supplied the previous year's accounts. Mr Sullivan said it was up to Mr Cadogan to decide on a business model, Ofsted wanted good managers and good resources.

76. Mr Kirwin took over as Inspector, because Mr Mackay had undertaken the role for more than three years and it was Ofsted practice to move inspectors on.

77. Ofsted met Mr Cadogan on 16 April 2016 and July 2016, in meetings chaired by Ms Adcock. The themes were the adequacy and inconsistency of staffing across the homes, the lone working practice operated across the homes, the poor quality and frequency of external monitoring reports, using the police unnecessarily to manage children with challenging behaviour, inspectors failing to have access to records as staff were unable to show them such that the recording system was not fit for purpose. Mr Sullivan acknowledged some improvements in 2015, but by the end of that year things had deteriorated.

78. We spent time looking at evidence on memos relating to the registration of Cordella Ifebogum the registered manager of Tubman House. Her application was received by Ofsted on 1 December 2014, but returned as her DBS was not on the update service. After 19 days it then lapsed and she was

informed that she would have to apply for another one. This was a very frustrating process to Mr Cadogan, who sought details of the DBS on the update system. Ofsted explained this could not be provided due to data protection reasons.

79. We asked Mr Cadogan number of very open questions when he came to give evidence so that we could get a better understanding of his way of thinking and why, despite being an obviously capable individual, he had not addressed the concerns raised consistently by Ofsted. He told us that he had no job other than at Ebonycare. He clarified that he was not a qualified manager or social worker, he had not undertaken any management qualifications but he was a capable manager through years of managing Ebonycare. He said he was undertaking an NVQ Level 5.

80. We clarified that Mr Cadogan had been represented by solicitor and counsel at the representations hearing. The notes record that they asked for him to have a 'final chance'.

81. Mr Cadogan decided to use a Direct Access arrangement and that is how he came to use the services of Mr Gledhill. He said he had not fully grasped what was required of him and that he would have to prepare the documentation. We clarified that he drafted his statement dated 30 of June 2017, citing technical problems for his lack of compliance, and his fuller statement dated 17 July 2017 himself. As Mr Menon QC stated this was really just 'a stream of consciousness' and did not address the specific issues, even if it did give a flavour of Mr Cadogan's thinking.

82. He also stated that he'd been going to seek independent advice from a Consultant approaching both Janjer, a company he had previously used to provide Regulation 44 Independent Visitor reports, and a company called Rezume. He produced a 90 page action plan on the 6th day of the hearing which we did not admit into evidence, as it was not a definite option, so not relevant. He told us that his plan was to put his personal property on the market at £1.4 million, although when later checked by Ofsted it had been reduced to £1.2 million.

83. When cross-examined, he was asked which breaches of regulations he accepted. He accepted that he had breached the requirement to file monitoring reports by independent visitors and that he had been late paying fees on a number of occasions but said no others "sprung to mind" and he asked to be reminded of the regulations.

84. He suggested that Ofsted were trying to influence things in their favour. He denied that he had been advised by managers of the homes not to make a complaint about Ofsted. He did not accept that there was not always a first aider on site, however, he stated that all staff had been trained in first aid. He did accept that possible mistakes were made in relation to medication and that it would have been a good idea to have both electronic and manuscript records.

85. He was taken through the history of a number of the young people and had to be asked on a number of occasions to answer the question. He referred to Ofsted 'having it in for him' and the periods 'pre-and post witchhunt', which hindered Ebonycare's progress.

86. On staffing, Mr Cadogan refused to accept that lone working, as opposed to one to one working, was a breach of regulations.

87. Mr Cadogan declined to accept that Ofsted had never been able to see a full set of staff records. He said he had given the inspectors a pass code to enter the system which they could have used to inspect the records but he refused to accept that they were not accessible.

88. As the RI he decided with the registered manager which young people to accept. Mr Cadogan emphasised his belief that the one Key policy, in which he held the only key, was a preventive measure ensuring that unauthorised persons did not have copies of the keys. It was suggested to him that the 'one key policy that was in reality him exercising a high degree of control, which was both unnecessary and wasteful of time of Police and others. '

Closing Submissions

89. Mr Reed submitted Ofsted presented a fair and balanced case. Inspections were carried out by very experienced inspectors providing detailed evidence in contrast to the Appellant's lack of evidence. Mr Cadogan been unable to give straight answers, been prepared to make extreme allegations out of time, such as racism, corruption and a witchhunt. Whether they were believable or not they have been used to create a smokescreen.

90. The setting had received special treatment in that meetings had been set up both formal and informal, inspections had taken place by appointment. In contrast it was notable Mr Cadogan had not been able to produce any witness to support him.

91. Ofsted's evidence was supported by evidence from the LADO, social services and reports from Independent Visitors who had been engaged by Mr Cadogan.

92. The breaches of regulations were in Ofsted's view serious and systemic. Mr Cadogan made no formal admissions save for regulation 44, Independent Reports.

93. Mr Cadogan maintains his belief that there has been a witch-hunt when in fact Ofsted has tried many means to support Mr Cadogan. Ultimately Ofsted is driven to the conclusion that he is unlikely to change as many opportunities have been given to change but few have been taken.

94. There have been major breaches of regulations across all six homes and failures to address requirements across all six. For example lone working continues across the homes and unsafe staffing levels and recruiting remain.

95. Further to his request, we allowed Mr Cadogan to reflect on his closing submissions overnight. He accepted his preparation for the hearing was "mess". He knew that he had made mistakes and that in the past he had not been ready to hear this. He never set out to frustrate Ofsted or the tribunal process. However none of the breaches were so serious that the Homes should be closed for good. He took us to the history of the settings that they offer a unique service to black children which most others could not match. He took the responsibility for any failure. He said there was absolutely no doubt in his mind that race and racism played some part in Ofsted's decision. He agreed he should have made an immediate complaint but he was trying to make sense of it. There been too many incidents where racist and sarcastic comments had simply been brushed aside.

96. He wished to have time to work on the risk assessments training and recruitment and develop core teams. He appreciated at times communication with local authorities had not always been as good as it should have been. He did not ignore risks and had extensive experience of young people. Even at this late stage he wanted to get 'round the table' with Ofsted and 'thrash out how things could now be done'. Regulation would be at the heart of everything they did in the future. Mr Cadogan was emphatic in saying he had never harmed a child (for the avoidance of doubt that is not part of Ofsted's case) and did not want a valuable resource to be lost, not only to black and ethnic minority children but the whole community who has benefitted from care provided by Ebonycare Ltd.

Conclusions and Reasons

Evaluation of the evidence generally

97. Before turning to our findings we set out our broad assessment of the witnesses who appeared before us. We find that the professional witnesses called by Ofsted provided honest evidence, supported by notes written at the material time or soon thereafter. They were all prepared to acknowledge improvements made by the setting, the skill demonstrated by individual staff and to make concessions where appropriate. They gave time for change to take place. We consider that they all provided balanced, reliable evidence.

98. In particular we were assisted by the measured evidence and in depth experience of Mr Mackay, who had a practical way of bringing to life the regulations and consequences of the breach of failure and the impact that breaches had on the emotional and physical care of children. He has a very long experience in childcare and as an Ofsted Inspector. He took steps to give a 'steer' to Mr Cadogan when requested, for example for the names of persons to carry out the independent monitoring visits, whereas other inspectors might simply have kept within their regulatory role. Mr Cadogan used this against him in saying he suggested a Consultancy whose fees he considered too high although he had used them and it was ultimately his choice. Having heard Mr McKay we are confident that at all times he made his role clear.

99. Mr Sullivan and Mr Kirwin are also inspectors with a long experience in childcare. Both gave very detailed reasons for their conclusions, including talking to staff and children. Ms Graves monitored a visit and found Mr Kirwin's inspection practice appropriate. We were struck by the number of meetings both formal and informal that have taken place in this case, in order to give Mr Cadogan an opportunity to put things right.

100. Conversely Mr Cadogan has not presented a straightforward case, where he has complied with directions at all. Until his final submission it was not clear what he intended to do and even then it was only an aspiration.

101. Mr Cadogan is an eloquent and intelligent individual who we can accept was committed to carrying on the work started by his parents. He spoke with knowledge about the children and the risks at which they placed themselves and others. However he was impervious to suggestion, despite his own lack of formal qualifications in either management or social work and could not take what, we accept, was intended to be constructive criticism. Instead he made formal complaints and worked under an assumption that Ofsted were "out to get him". We found no evidence to support that they were. The evidence supports the contrary.

102. The defects in his case became even clearer when Mr Cadogan was cross-examined. He was unable to give straight answers and had to be reminded many times to answer the question. We were struck that not one member of staff came to support him and/or his case. This was not a case where the company lacked resources. Whilst there was talk of no less then four independent consultants being used, there was no Action Plan for us to consider. He volunteered that his consultants told him to steer away from criticising Ofsted and work on meeting the regulations. At various points Mr Cadogan consulted three different lawyers. Again the note of the Representations Meeting showed that he wanted one final chance to put an Action Plan together. He again volunteered that he had been advised to put together a case that showed compliance with the Regulations.

103. A notable recent development has been that the Appellant has refused Ofsted access to the homes in a number of occasions. This was despite appointments being made and cancellations happening when for example, Mr Kirwin was already travelling to the site, having made it known that he would have to set out early. We accept that this is not just unlawful but showed a complete disrespect for the Inspector. Junior members of staff were, we accept, instructed by a "senior member of staff", likely to be Mr Cadogan, not to let Ofsted in.

104. Allowing Ofsted access to homes is a statutory requirement under Section 31 of the Care Standards Act 2000. Mr Sullivan told us, in his long experience, he had never come across this denial of access before. We accept his evidence that the junior member of staff who opened the door refused him entry citing instructions from a more senior member of staff.

105. We are invited and do draw inference from the most recent refusals of access. We conclude that Mr Cadogan did not wish Ofsted to obtain further evidence that he knew the homes were not meeting the statutory requirements. This does not on past history over a long period suggest that they are likely to comply in the future.

The breaches of requirements

106. In relation to many of the breaches the Appellant's case has been struck out. In the absence of any contrary evidence we can and do find that these are approved without the need for detailed enquiry. These were the breaches as set out in C184-191 and set out in the order dated 14 September 2017. Mr Cadogan had many opportunities for submit evidence on these points and failed to do so.

107. We then examine a number of themes and breaches of a Regulation, albeit they are all interlinked. For ease we refer only to the 2015 Regulations but make clear the breach was also established under the 2001 Regulations at the time they applied.

Independent visitors: Regulation 33 2015 regulations

108. Ofsted provided ample evidence there was a particular failure to provide monthly Independent Visitors reports as required by Regulation 44 2015 Regulations. In the period analysed by Mr Slater, only 40% of the reports were submitted. In the first six months of 2016 compliance was approximately 50%.

109. We find that the reports were not always acted upon and as with the reports of Ofsted inspections and Compliance Notices, the response was patchy. For example, Lynda Claydon of Janjer noted in October 2016, 5 out of 6 of her previous recommendations had not been met. This we conclude was part of a pattern the Appellant Company ignoring the recommendations made.

110. Further examples of that were that the MAR sheets were not recording the administration of medications and this remained undeveloped over several months. We read examples of repeated advice to update risk assessments and health and safety policies especially around knives and weapons. The purpose of independent visitors is to look at safeguarding mechanisms for staff and children, resulting in advice and consultancy to managers. The intention is that it is helpful and supportive giving guidance to meet the statutory regulations. The advice was not taken. The reports mirrored Ofsted's findings and recommendations. Advice and suggestions were ignored or only partially complied with. Reports were not sent to Ofsted breaching regulations.

111. We heard and read a great deal about a young man called DB, who had a history of aggression and was very strong and tall. He assaulted Ms Bush who was noted to have a good relationship with him. The independent visitors report that the daily log showed he was spending most of the day in

his room or at the music studio that had been created for him, so he received no meaningful interaction most of the time. The report went so far as to say about lone working that "presently the arrangements are inadequate and unsafe". The response was that the lone working risk assessment would now incorporate de-escalation techniques, but no reference was made to being able to call for support from staff promptly as part of a risk assessment. We make it clear that this is but one example.

Management Monitoring Reports. Regulation 45

112. This was mirrored by the failure to submit management reports. Very few were received, nine out of a possible thirty. This was also reflected in the lack of staff trained in child protection and first-aid at each site at all times.

Safe recruiting. Regulation 32

113. Safe recruiting is s a very basic requirement and we would expect to see this embedded in an organisation, with evidence that any gaps in employment history had been adequately probed. This was a repeated theme and the only conclusion that we can reach is that if the evidence is there then it was not readily accessible as it should have been. . For example, in relation to Ebony House a Compliance Notice was issued on 16 March 2016 because there was no evidence of recruitment checks for the Registered Manager and one other member of staff. This should be readily available to anybody, including the Ofsted inspectors who couldn't access the electronic records at Rural Way on 15 16 September 2015. It was not sufficient to offer them a password, the manager should have been able to access this at all times.

114. These are not isolated incidents. Again at Rural Way in February 2016 the staff records couldn't be accessed and those seen showed shortfalls. A further Compliance Notice was issued in July 2016 and was still unmet by October 2016.

115. Lack of such access was across all six homes; there was still no access to the electronic records at Satchmo House on 22 September 2016 and 18 September 2016 at Tubman House. It was only possible to check one record and basic information such as verifying the workers identification was not available, nor was there evidence of their eligibility to work in the UK.

116. Such was the concern of Mr McKay that he attempted to audit all the recruitment records. We looked at the number of examples he highlighted, of which no adequate explanation has been given. The end result was he never saw full records. This we conclude left vulnerable children being cared for by potentially inappropriate people. It meant Managers did not have a full knowledge of the staff. Mr Cadogan was put on notice about this on many occasions but failed to remedy it.

117. This was another example of where Mr Cadogan had to have control, as managers did not always know how to access the computer system that he devised. We accept Mr Mackay had made very clear to him his concerns

about safe recruiting but Mr Cadogan merely sent in the documents he wanted him to see.

Staffing levels: Regulation 31

118. We find evidence that it was at times inadequate and if it was not did not work effectively. This issue exemplified the measured approach of the inspectors in that they all acknowledged that there were some good well-intentioned staff, who had good skills and professional commitment. However, there was no chance to meet as a team and develop reflective practice with a key directional strategy to support a young person. We have already highlighted the dangers of lone working with a female member of staff working with the young person charged with rape. Rotas were not available or easily understood by the staff. We were not satisfied that if for example an allegation was made it would have been possible to know who was on duty. More particularly, despite Mr Cadogan stating that the 'one key policy' was there so that the young people knew who was coming on duty, there was clear evidence from a number of sources that they did not, because they changed so often. This clearly did not meet their needs for structure and routine and opportunities to develop key relationships.

119. It was striking that a number of social workers complained about poor communication, despite the very high fees being paid. We were struck by the by the evidence of Mr Onwubuye that a looked after child told him in conversation that "*Ebonycare was just selling dreams"*, that is they made promises but failed to deliver. Whilst seven or eight staff may have worked in a home that didn't make them a core team.

Training: Regulation 13 and 35.

120. This was another example of there being some compliance but it was again very patchy. We saw a few certificates but not a consistent staff log and audit as we would expect. Individual managers such as Ms Sonia Lowe did some work on this, but overall all it was inadequate.

121. The evidence of Mr Mackay echoed the Tribunal's own concerns that there was a lack of transparency and accountability. It was not clear how Mr Cadogan as the Registered Individual monitored and identified what new areas of training might be needed. The evidence again did not support that all staff could access this. This sat alongside the failure to prepare and implement an adequate behaviour risk management policy with no evidence of specialist training in relation to physical restraint.

122. Mandatory training was not adhered to i.e. safeguarding, Risk Assessments, Child Protection, Safe Restraint, First Aid training, fire safety, behaviour management, radicalisation and safe physical interventions. Each shift needed to have one member of staff who had completed First Aid training. This wasn't the practice in daily shifts.

Risk Assessments-Generally Regulation 12 (2)(b) & 34 2015 Regulations

123. Overall the evidence establishes that in relation to each home they were not consistently fit for purpose. The Risk Assessments were not sufficiently updated, accessible or actioned reflecting changing risks of the child. Mr Cadogan as the Registered Individual failed to arrange care and support so as to keep each child safe and protect each child effectively from harm and the staff who worked with them.

124. Risk Assessments were not reviewed at regular intervals as a team. We found no clear evidence that assessments were used as a working documents, handed over to shift staff, with the risk then continuing to be monitored.

125. We read of many examples of poor risk assessments, also picked up by the Independent Visitors. We have already referred to the example of the young person for whom Mr Onwubuya was the social worker. Mr Cadogan was in our view correct in his assessment of risk in letting the young person have their passport but did not translate this into a risk assessment, he not appreciate the importance of recording this in the young person's care plan so that it could tie in with other concerns. All he would have had to do was record his concerns and put it into practice.

126. Lone working was we conclude an unsafe working practice - There were no risk Assessments only reactive decisions A great deal of time was spent looking at and agreeing a definition of 'lone working' which is where there is no other staff member on site. It does not preclude working one to one. Lone working by its nature is inherently risky with this high needs group. We accept the submission by Ofsted that it should not never take place but a particularly robust accompanying assessment is needed. The prime example of this was DB a well built and tall young man who had a long history of violence and aggression, often triggered without warning. He was assessed as being at high risk of reoffending and a moderate to high risk of violence. His social worker expressed concern, the independent visitor and the manager expressed their concern and Dr Packer expressed concern. We accept Ofsted's submissionthat a robust risk assessment would have inevitably concluded that lone working was not safe for this young man, particularly with females. We reject the suggestion that more than one member of staff could cause DB to react poorly, or the authority had refused to fund another worker. The issue must be the clearly identified risk. It was for the RI to make an assessment of what level of staffing was safe.

127. We spent some time examining whether other staff could be summonsed in an emergency. That doesn't bear scrutiny because although some of the homes were close to each other, others were not. In any event those homes with one member of staff on duty were also caring for another young person. Inevitably the nature of the crisis meant staff needed to respond and support immediately. Ms Bush was assaulted in the stomach and Mr Cadogan sustained very serious injury as his leg was fractured. We noted how often the police have been called in to deal with an incident with a

child.

Care of Children Regulation 31 2015 Regulations.

128. Given the history of these young people, building meaningful one-to-one relationships was clearly paramount for their care and well-being. However there were numerous examples of a lack of continuity of staffing. The Appellant Company paid for frequent use of Agency staff and or staff transfer between the homes. It is such an important factor that Regulation 31 provides for it and we find it was not provided here. Poignantly it was the subject of comment by the young people themselves as well as the Independent Visitors.

Leadership and Management: Regulation 31

129. Leadership and management was overall crisis led, a reactive and not proactive service. The children in the Homes had high levels of needs but the Appellant Company was not allowing the mangers to manage and not ensuring they were supported to carry out their duties effectively.

130. We saw no clear evidence of how the RI supported newly appointed registered managers coming newly into post and establishing their particular leadership style and approach within their team. There was a failure to have in place core teams for each home. We find there were numerous instances where there was insufficient staff on duty.

131. Mr Cadogan as the RI showed a lack of good judgement and understanding. He lacked the skills to lead a team. The RI must have the skills, the patience, the relationship-building qualities, the judgement, accountability and other qualities that allows them to interact effectively with their staff and lead them forward to provide care and good standard working practices for young people within a safe home. That must include recognising the need to comply with the Regulations and Ofsted's role in monitoring, inspection and enforcement. Mr Cadogan was unable to demonstrate such qualities.

Health and Safety

132. There was a failure to ensure monitoring and audit trail of control, restraint or discipline.

133. Pursuant to Regulation 25 (1)(d) 2015 there was failure to hold fire drills at regular intervals to safe guard the young people and staff. There was also a failure to ensure all parts of the home to which children have access are free from hazards i.e. broken glass, infestations, hygiene, storage of food, removal of household waste.

134. Pursuant to Regulation 31(2)(d)(e) there were examples of a failure to ensure that parts of the home was in good repair.

Conclusion:

135. Ofsted have made out their case. They have put together factual detailed evidence to support each allegation made. The breaches set out in the Scott Schedule dated 14 September 2017 are made out.

Proportionality

136. There were a large number of breaches, extending across all the homes over at least three years. Overall the pattern is a deteriorating compliance with the regulations. We accept that the Appellant company has had numerous opportunities to address the deficiencies and comply with the Regulations. Compliance notices have proved ineffective in securing compliance.

137. It was striking that up until his final submission, even when served with very detailed evidence the Appellant failed to acknowledge any of the deficiencies even when he could not produce any documentation to show it was wrong. Instead he took a position of outright denial or raising issues of bias or institutional racism by Ofsted.

138. At the date of the hearing was no evidence of improvement over the months since the appeals were lodged. An Action Plan was put forward in May 2014 but did not bring about sufficient improvement. The second was produced on 28 November 2016 at the representations hearing when the Appellant Company had the benefit of lawyers and access to a Consultant. This was not taken forward.

139. It is the responsibility and duty of the Registered Person to ensure that regulations are complied with at all times. The same funding limitations apply to other registered providers working in the sector, most of whom achieve compliance.

140. The Appellant has consistently failed to comply with the regulations set out above. Taking all of the circumstances of the systematic failures to sustain the care, welfare and safeguarding of children in Ebonycare by persistent breaches of Children's Homes regulations, the only appropriate outcome is for us to dismiss the appeal and uphold Ofsted's decision to cancel the registration. We do not consider that conditions are appropriate or practicable when the Appellant has already been provided with numerous opportunities to bring about change and each home is already subject to a restriction.

Decision

The appeal is dismissed.

The decision of Ofsted dated 12 December 2016 to cancel the registration of:-

Ebony House

Satchmo House
Rural Way
Tubman House
George Washington Williams House
Maya Angelou House

is upheld.

Judge Melanie Lewis
Primary Health Lists/Care Standards
First-tier Tribunal (Health Education and Social Care)
Dated: 23 November 2017