Care Standards

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

Considered on the Papers on 18/10/19

[2019] 3852.EY-MoU

BEFORE
Timothy Thorne (Tribunal Judge)
Wendy Stafford (Specialist Member)
Caroline Joffe (Specialist Member)

BETWEEN

Pilgrims Corner Ltd

Appellant

-v-

Ofsted

Respondent

DECISION

The Appeal

1. Pilgrims Corner Ltd (A) appeals to the Tribunal against Ofsted's decision dated 16/09/19 to restrict accommodation at their setting Spencer Cottage ("the Home") for a period commencing from 16/09/19 until 08/12/19.

Paper Determination

2. The appeal was listed for consideration on the papers, pursuant to rule 23 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 (2008 Rules). Both parties must consent, which they have in this case, but the Tribunal must also consider that it is able to decide the matter without a hearing.

3. In this case, the panel concludes that it has sufficient evidence regarding the allegations made and the conclusions reached. In the circumstances, the panel considers that it can properly make a decision on the papers without a hearing.

Restricted Reporting Order

4. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the users of the service in this case so as to protect their private lives.

Background

5. A was first registered on 28/03/14 to provide at the Home accommodation for up to 2 children including those with emotional and/or behavioural difficulties. A runs a number of similar homes.

6. Ms. Sarah Norman is the owner of Pilgrims Corner, and the Registered Provider/Responsible Individual of the company that owns and manages the Home and other homes as well as an independent school. Since 21/03/19 the Registered Manager of the home (RM) has been Ms. Shanelle Maxwell-Amayigha.

7. Between 2016 and 2018 the Home had been inspected 4 times and found to be good except on the last inspection on 23/10/18 when it was found to require improvement. Then on 24/07/19 and 25/07/19 a full inspection was conducted by Ofsted and the Home was found to be inadequate. At that time there were 2 children living there.

8. The widespread and serious breaches of the Children's Home (England) Regulations 2015 ("the Regulations) that were found are outlined in detail in R's evidence set out below. In particular, breaches of Regulations 12 (Protection of Children), 13 (Leadership & Management) and 25 (Fire Precautions) were identified.

9. As a result of these deficiencies, Compliance Notices dated 14/08/19 were issued by Ofsted with actions to be completed by 08/09/19. On 10/09/19, Ofsted conducted a monitoring visit at the Home. By this time there was only one child living there. The inspector discovered that the improvements required by the Compliance Notices had not occurred and there were concerns regarding the lack of adequate systems in place to protect child B and staff.

10. There were now significant additional concerns about the one child who remained, child B. These are outlined in detail in Ofsted's evidence set out below. Ofsted therefore later issued a Restriction Notice dated 16/09/19 which is the subject matter of this appeal.

Late Evidence

11. On 16/10/19, A requested that new material be submitted into evidence. This was in the form of a witness statement dated 16/10/19 from Ms. Sarah Norman.

12. In relation to this new material, the Tribunal applied rule 15 of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care

Chamber) Rules 2008 and took into account the overriding objective as set out in rule 2 and admitted the late evidence as it was relevant to the issues in dispute.

Evidence

13. The panel took into account all the evidence that was presented in the bundle. The following is a summary.

The Respondent's Evidence

14. In his witness statement dated 10/10/19 **Mr. Stephen Collett** indicates that he has been an Ofsted inspector since 2014. He conducted the **inspection of the home on 24/07/19 and 25/07/19**. A precis of the deficiencies he found during that inspection are set out below:

15. Regulation 12 (Protection of Children) – At the time of the inspection child A (who was 12 years old) lived at the Home along with child B who was 15 years old. Child A was the subject of 2 police investigations. One concerned allegations of sexual assault. The other was an allegation of arson. The Home's risk assessment on child A was inadequate as it referred to a 10 year old girl who A had admitted sexually assaulting as his "girlfriend." It demonstrated a lack of understanding about abusive relationships.

16. The risk assessment was also inadequate as it failed to take account of child A's long history of sexually harmful behaviour and the resultant risk that he might enter child B's bedroom during the night whilst staff were sleeping. There were no systems to alert staff of this happening and the risk assessment contained no guidance to staff as to how to minimise the risk that child A might target other children in public.

17. Child A had admitted setting a fire next to a nursery but his fire setting risk assessment was merely generic and did not indicate that specialist advice had been sought.

18. Child A was known to be at high risk of harming himself and other children. On at least 2 occasions he had absconded from the Home without staff knowing. He had gone to another of the children's homes run by A and had entered the room of a female child. The Home's risk management strategies were therefore ineffective.

19. Regulation 13 (Leadership & Management) – Prior to admitting child B to the Home in June 2019, managers failed to carry out an effective assessment of what impact the 2 children would have on each other. The risk assessment contained insufficient analysis of the potential for bullying by child B of child A. Subsequently child A was seriously assaulted by child B on a number of occasions. The impact assessment also failed to consider the risk that child A would persuade child B to abscond with him which he did on a number of occasions.

20. Also Ms. Norman and the RM were unable to provide reliable evidence of the necessary staffing levels to keep both children safe and consistently cared for. Six members of staff had recently left and there was no clear guidance as to whether female staff should care for child A despite the fact that he had a history of violent and sexualised behaviour towards female staff.

21. In addition the necessary 6-monthly "quality of care review" required under Regulation 45 had not been conducted for the last 15 months. Recommendations made by the Home's independent visitor had not been acted upon. The necessary monthly internal quality assurance audits had not been completed since April 2019.

22. Child A's sexually harmful behaviours had worsened over the last 3 years and records indicated that staff had received no training on how to support, care and manage children who demonstrate sexually harmful behaviours.

23. There was also an inappropriately conducted internal investigation following an allegation made by a child about Ms. Norman in December 2018. Instead of appointing an independent person to conduct the investigation she appointed the RM.

24. Regulation 25 (Fire Precautions) – Records demonstrated that the Home's fire risk assessment had not been updated in May 2019 to take into account that child A had admitted setting a fire and that his bedroom window was permanently locked to prevent him absconding again. Neither child had a personal emergency evacuation plan.

25. Mr. Collet returned to the Home for a **monitoring visit on 10/09/19** to check on the progress made in relation to the aforementioned deficiencies. By this time child A had left the Home and only child B was living there. Mr. Collet discovered that the compliance notices had not been met and there were now additional concerns about child B. A precis of what Mr. Collet found is set out below:

26. Regulation 12 (Protection of Children) – The risk assessment about child B's sexually inappropriate language to females was reviewed on 22/08/19. It was recommended that he undergo regular key work sessions about this problem. However the records showed that none of the sessions between 02/08/19 and 01/09/19 dealt with sexually inappropriate language as they should have done.

27. Documents recorded that child B had removed fire extinguishers and smoke alarms and set off extinguishers. However, his fire risk assessment made no mention of these incidents.

28. There was also an incident on 08/09/19 when child B threatened a member of staff who was working alone for 6 hours. No risk assessment had been undertaken about lone working in violation of the organisations lone working procedures.

29. Child B's risk assessment about bullying dated 03/09/19 had strategies which were badly developed and only assessed him as posing a medium risk when he was on his own but that it might increase if another child moved into the home. Mr. Collet was concerned that these risks had not been adequately identified or guarded against.

30. There was also inadequate evidence that staff had been trained to identify and act upon signs that a child might be at risk. Ms. Norman claimed that all staff had renewed their safeguarding training but this was discovered to be untrue. There were no staff competency assessments or skills audit. Only 2 staff members had completed training for working with children who (like child B) had experienced significant domestic violence.

31. Mr. Collet gave 2 examples of serious shortcomings in the care of child B which were recorded as having occurred after the original inspection. On 08/09/19 child B had threatened violence to a staff member who when calling for assistance encountered only an ineffective response. This incident, during which only Child B and the one staff member were present, lasted several hours. Management were not informed and no adequate assessment was made of the risks. The other example related to Ms. Norman's failure to consider whether child B's medication may have contributed to his challenging behaviour.

32. Ofsted contacted the placing authority on 12/09/19 and on 16/09/19 Laurence Doe from the authority informed Ofsted of the results of their own investigation. It was noted that the deterioration in child B's behaviour did coincide with the change in his medication. On 11/09/19 his GP stopped the medication.

33. Regulation 13 (Leadership & Management) – Mr. Collet examined a compliance action plan but many of the actions had no completion date despite the compliance notice specifying a completion date of 08/09/19. There was no core team of staff at the Home as they were shared across other homes owned by A. There were insufficient staff at the Home to adequately care for child B at all times.

34. The compliance action plan had not been fully implemented in relation to improving the standard of quality of care monitoring systems. An incident where a member of staff had upset child B by saying he would grow up to be a drug dealer was not identified through the Home's monitoring system and the poor practice had therefore not been addressed.

35. The necessary monthly internal quality assurance audits had still not commenced. Also the RM had not informed the directors or shared with the staff Ofsted's concerns.

36. Regulation 25 (Fire Precautions) – the Home had failed to employ an independent fire safety consultant as required under the compliance action plan. Moreover the Home's internal fire risk assessment had no risk rating

and identified no areas for improvement. Child B's personal fire risk assessment made no mention of his predilection for misusing fire equipment.

37. Moreover, child B's personal emergency evacuation plan dated 23/08/19 made no reference to the possible soporific effects of his medication which included drowsiness, dizziness and visual disturbance. In addition Ms. Norman was unable to produce any records of staff fire safety training.

38. In conclusion, Mr. Collet stated that the Home had not evidenced that the requirements of the Compliance Notices had been met and in addition there was evidence of recent poor practice that exposed child B to a risk of harm. His evidence was supported by the contemporaneous notes that he made of the first inspection which were exhibited as SC/2 and the notes he made of the monitoring inspection which were exhibited as SC/4. The inspection report from the fist inspection was exhibited as SC/1.

39. Ofsted held case review meetings on 11/10/19 and 12/10/19 and a decision was made to restrict accommodation as a necessary and proportionate step in order to safeguard children from a risk of harm from further admissions to the Home.

40. In her witness statement dated 14/10/19 **Ms. Stephanie Murray** indicates that she has been an Ofsted senior inspector since 2017. She was involved in the case review about the Home conducted on 11/09/19 (which heard from Mr. Collet) and she explained in detail the process by which Ofsted decided to restrict the accommodation. It was concluded that the Home had failed to meet any of the compliance notices and that the proportionate response would be to restrict accommodation. More draconian responses were considered but it was concluded that they were not necessary. Ofsted would continue to keep the decision to restrict further admissions under review.

The Appellant's Evidence

41. This comprised the "Reasons for Appeal" drafted by Ms. Sarah Norman and her witness statement referred to above. The "Reasons for Appeal" can be summarised as follows:
    a. The grounds relied upon by Ofsted and the language employed were not appropriate.
    b. Ofsted had relied on speculation and unsubstantiated claims.
    c. The inspector was not medically qualified to assess the effects of child B's medication
    d. Child B's sexualised language and approach to female staff was not "concerning sexualised behaviour".

42. The witness statement of Ms. Sarah Norman can be summarised in the form of selected representative quotations from the document as follows:
    a. "I have operated children's Residential care for over 15 years, improving the lives, opportunities and outcomes for young people. I

would describe my relationship with Ofsted as positive and typically co-operative."

b. "In my role as Responsible Individual it is my role to provide strategic oversight of my homes and support the managers of these homes to safeguard and promote the welfare of the young people."
c. "In this role my managers manage some of the most complex, challenging and difficult young people…."
d. "Like most providers, there are times when we struggle to manage behaviours that young people may have exhibited for many years…."
e. "I believe that care standards have not been maintained to the standards I have typically met and been reflected through my previous Ofsted inspections."
f. "I do feel that in this case, the inspector and Ofsted have not acted in the manner that has previously been experienced. Instead acted in a manner that has sought to inflate, and conflate areas where practice is weaker and conclude that we cannot provide any semblance of good care….exampled through the 'padding out' and speculative gathering and consideration of evidence."

The Legal Framework

43. Section 22B of the Care Standards Act 2000 provides a power for the registration authority (Ofsted) to serve a notice on a person who is registered in respect of an establishment, imposing the requirement under subsection (2), which states;
(2) The requirement is to ensure that no child is accommodated at the establishment unless the child –
(a) was accommodated there when the notice was served; and
(b) has continued to be accommodated there since the notice was served.

44. Section 22B (8)(a) specifies that the section applies to 'children's homes'. Section 21(1) (c) of the Care Standards Act 2000 specifies that an appeal against the decision to restrict accommodation shall lie to the Tribunal.

45. There is no statutory test to be applied when considering the threshold for restricting accommodation. However, paragraph 200 of the Ofsted Social Care Compliance Handbook states the following:- *'We only serve a notice restricting accommodation where we reasonably believe that a child, young person or adult may be at risk of harm if we allow further admissions and do not restrict accommodation. We take into account the individual circumstances of each case when deciding whether restricting accommodation is the appropriate action to take.'*

46. On appeal, the Tribunal steps into the shoes of the Inspector and the question becomes; does the Tribunal reasonably believe that the restriction of accommodation is necessary and proportionate based on reasoning provided?

47. If the Tribunal adopts the threshold applied by the Respondent when considering a restriction of accommodation, the Tribunal will need to

consider 'as at the date of the decision, does the Tribunal reasonably believe that a child, young person or adult may be at risk of harm if further admissions are allowed and the accommodation is not restricted'.

48. The burden of proof is on the Respondent. The standard of proof lies between the balance of probabilities and a reasonable case to answer. The belief is to be judged by whether a reasonable person assumed to know the law and possessed of the information, would believe that a child, young person or adult might be at risk.

Conclusions & Reasons

49. For reasons given below the panel concludes that the Respondent has proved to the requisite standard that a child, young person or adult maybe at risk of harm if further admissions are allowed and the accommodation is not restricted. The panel's reasons are set out below.

50. The panel is satisfied on the balance of probabilities that the evidence of Mr. Collet is honest and reliable. His account about what he did and saw during the inspections and later compliance visit is consistent and corroborated by his contemporaneous notes and other documents exhibited in the case.

51. In light of this evidence the panel is satisfied on the balance of probabilities that the inspection of the home on 24/07/19 and 25/07/19 uncovered the deficiencies set out in his evidence and summarised above. The panel is also satisfied that these deficiencies when taken together constituted widespread and serious breaches of Regulations 12 (Protection of Children), 13 (Leadership & Management) and 25 (Fire Precautions).

52. In particular, in light of the evidence outlined above, the panel accepts that:
    a. The Home's risk assessment on child A was inadequate
    b. The Home's risk management strategies were ineffective.
    c. Managers failed to carry out an effective assessment of what impact the 2 children would have on each other.
    d. Ms. Norman and the RM were unable to provide a reliable account of the necessary staffing levels.
    e. There was no clear guidance as to whether female staff should care for child A
    f. The necessary 6-monthly "quality of care review" required under Regulation 45 had not been conducted for the last 15 months.
    g. Recommendations made by the Home's independent visitor had not been acted upon.
    h. The necessary monthly internal quality assurance audits had not been completed since April 2019.
    i. Staff had received no training on how to support, care for and manage children who demonstrate sexually harmful behaviours.
    j. The Home's fire risk assessment had not been updated where necessary

53. In those circumstances the panel is satisfied that it was necessary and proportionate for Ofsted to issue the Home with Compliance Notices dated 14/08/19 which identified the deficiencies and set out the actions that were to be completed by 08/09/19.

54. In light of the evidence the panel is also satisfied on the balance of probabilities that Ofsted's monitoring visit at the Home on 10/09/19, uncovered the fact that the improvements required by the Compliance Notices had not occurred and there were concerns regarding the lack of adequate systems in place to protect child B and staff.

55. In particular, in light of the evidence outlined above, the panel accepts that:
    a. None of the sessions with child A between 02/08/19 and 01/09/19 had dealt with sexually inappropriate language as they should have done.
    b. Child B's fire risk assessment had not been updated.
    c. No risk assessment had been undertaken about lone working in violation of the organisations lone working procedures.
    d. Child B's risk assessment about bullying was inadequate
    e. There was inadequate evidence that staff had been trained to identify and act upon signs that a child might be at risk.
    f. Staff had not renewed their safeguarding training
    g. There were no staff competency assessments or skills audit.
    h. Staff had not completed training for working with children who (like child B) had experienced significant domestic violence.
    i. Many of the actions in the compliance action plan had no completion date despite the compliance notice specifying a completion date of 08/09/19.
    j. There was no core team of staff at the Home as they were shared across other homes owned by A.
    k. There were insufficient staff at the Home to adequately care for child B at all times.
    l. The compliance action plan had not been fully implemented in relation to improving the standard of quality of care monitoring systems.
    m. The necessary monthly internal quality assurance audits had still not commenced.
    n. The RM had not informed the directors or shared with the staff Ofsted's concerns.
    o. The Home had failed to employ an independent fire safety consultant as required under the compliance action plan.
    p. The Home's internal fire risk assessment and emergency evacuation plan were inadequate.
    q. There were no records of staff fire safety training.

56. In those circumstances the panel is satisfied that it was necessary and proportionate for Ofsted to have issued the Restriction Notice dated 16/09/19 which is the subject matter of this appeal. The panel also accepts the evidence of Ms. Stephanie Murray that the proper and lawful procedures

were followed (in line with Ofsted's policy) in making this decision and that it was the least draconian outcome open to her in the circumstances.

57. In coming to this conclusion the panel has of course considered the evidence of Ms. Sarah Norman as set out above. However it is a marked feature of this case that there is a lack of evidence from her actually disputing the main findings of Ofsted and a lack of evidence of what if any measures were taken by the Home to meet the requirements of the Compliance Notices. In fact she said in her witness statement that "I believe that care standards have not been maintained to the standards I have typically met and been reflected through my previous Ofsted inspections." This is effectively an admission that Ofsted's concerns were warranted.

58. Moreover, the panel does not accept Ms. Norman's claims that Ofsted "sought to inflate, and conflate areas" and were guilty of 'padding out' and speculative gathering and consideration of evidence." The panel is satisfied that Ofsted behaved properly and lawfully throughout the procedure.

59. In addition the panel is concerned that Ms. Norman appears to have misunderstood the nature of the inspector's complaints about child B's medication and still does not realise the shortcomings shown by the management in the Home in not at least considering the implications of his medication in risk assessment.

60. Moreover, the panel is concerned that Ms. Norman appears to have minimised the serious effects of Child B's sexualised language and approach to female staff by characterising it as not "concerning sexualised behaviour."

61. The panel is therefore satisfied in the light of all the evidence that if another child was admitted to the Home now, the staff and provider would not have the sufficient time, resources and skill to address the identified shortfalls which are still unremedied and therefore create a risk of harm. Therefore if another child was admitted there is a likelihood that the new child and or child B would be put at risk of harm.

62. Therefore the panel concludes that a child, young person or adult may be at risk of harm if further admissions are allowed and accommodation is not restricted. The panel also concludes that the restriction of accommodation is necessary and proportionate for the reasons set out in this decision.

Decision

63. The Appeal is dismissed and the Respondents notice dated 16/09/19 served pursuant to Section 22B of the Care Standards Act 2000 is confirmed.

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

Date Issued: 24 October 2019