First-tier Tribunal, Care Standards Tribunal

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

NCN: [2024] UKFTT 00095 (HESC)
[2023] 4842.EA

Hearing held on 30, 31 October and 1 and 2 November 2023 and 10 and 11 January 2024 at the Royal Courts of Justice

Before
Ms S Brownlee (Tribunal Judge)
Mrs Libhin Bromley (Specialist Member)
Mr John Hutchinson (Specialist Member)

Between:

Pinnacle Brit Care Ltd

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The appeal

1. This is Pinnacle Brit Care Ltd's ('the Appellant') appeal against a decision of the Care Quality Commission ('CQC' and 'Respondent') to cancel its registration as a provider in respect of the regulated activity of 'personal care', at Pinnacle Brit, 1 Meadlake Place, Thorpe Lea Road, Egham, Surrey, TW20 8HE. Mr Sunday Adesanmi, the nominated individual and registered manager of Pinnacle Brit Care Ltd, brings the appeal, on behalf of the Appellant and is, in effect, also the Appellant. Mr Adesanmi appeals the Respondent's decision of 28 December 2022 pursuant to section 32 of the Health and Social Care Act 2008 ('the Act') to the First-tier Tribunal.

The hearing

2. The initial hearing took place on 30 and 31 October and 1 and 2 November 2023. It had a time estimate of five days. The parties and all witnesses attended the hearing at the Royal Courts of Justice. The hearing adjourned on 2 November 2023. In order to fix the dates for the adjourned hearing to

reconvene and to ensure readiness for the hearing, a telephone case management hearing (TCMH) took place on 17 November 2023.

3. In advance of the hearing, the Tribunal had read the digital hearing bundle (running to 2016 digital pages) and skeleton arguments from both parties.

4. Some participants worked from hard copy hearing bundles and some from digital hearing bundles. All witnesses used the hard copy hearing bundles, apart from Mrs Mulhall, who used the electronic hearing bundle as a reasonable adjustment.

Attendance

5. Mr Adesanmi was represented by Ms Laura Nash, instructed by Ms Laura Hannah of Stephensons Solicitors LLP, during the hearing on 30 and 31 October and 1 and 2 November 2023. Mr Adesanmi gave some oral evidence and intended to call one witness, Ms Ellie Clarkson, consultant and mentor for Care Services Contractor at HLTH Group. The CQC was represented by Mr Tim Grey, instructed by Ms Sonia Khan of Hill Dickinson LLP. Mr John Okunpolor Junior, lawyer at the CQC, attended throughout the hearing. The Respondent called three witnesses, Mrs Clare Creech, inspector, Mrs Gail Winnery, inspector and Mrs Caroline Mulhall, inspection manager (at the time of the two inspections in 2022 and 2023), now senior specialist in autistic people and people with learning disabilities.

6. On 10 and 11 January 2024, Mr Adesanmi represented himself. The CQC was represented by Miss Jade Bucklow, instructed by Ms Sonia Khan of Hill Dickinson LLP. The Respondent's witnesses attended. The Tribunal heard further oral evidence from Mr Adesanmi and oral evidence from Ms Clarkson. Mrs Creech was recalled to deal with narrow points which had arisen for the first time during Mr Adesanmi's oral evidence on 2 November 2023 and 10 January 2024.

Preliminary issues

7. At 8.36 am on the first morning of the hearing, the Tribunal received an application from the Appellant to adduce late evidence. The Appellant sent the application and accompanying evidence to the Tribunal and the Respondent at 9.11 am on Saturday 28 October 2023. The Respondent confirmed that it first saw the application on the first morning of the appeal hearing, 30 October 2023.

8. The application consisted of a signed witness statement from Ms Ellie Clarkson dated 27 October 2023 and a number of documentary exhibits (running to 152 digital pages).

9. Mr Adesanmi had legal representation from the point at which he filed his appeal to the First-tier Tribunal in January 2023. Ms Nash explained that the application was made so late as her instructing solicitors were first made aware of Ms Clarkson on 23 October 2023, which also explained why there was no reference to the involvement of Ms Clarkson or the steps she had undertaken

at the point when Ms Nash's skeleton argument was drafted and sent to the Tribunal.

10. As a result of the update from Mr Adesanmi, immediate steps were taken to secure a witness statement from Ms Clarkson and collate the documents to which she could speak. The Respondent objected to the admission of the documents so late in the appeal process and several months after the final evidence deadline (final evidence deadline of 23 June 2023). Ms Nash submitted that the application was made as soon as it could be made in the circumstances, accepting that no reasonable notice had been given to the Respondent, given that it was put on initial notice of late evidence being finalised at 17.26 on Friday 27 October 2023. Ms Nash indicated that if the application was refused, Mr Adesanmi's instructions were to apply for an adjournment. In her submission, the evidence was relevant and not to admit it would be unfair to the Appellant, given the nature of the decision being appealed. She made the point that Ms Clarkson was in attendance and prepared to answer questions under oath or affirmation. In her submission, the Tribunal was not being asked to consider documentation that had a significant degree of detail – by and large, the documentation consisted of templates.

11. Mr Grey opposed the application. He brought the Tribunal's attention to the previous case management orders, setting clear deadlines for both parties, to which the Respondent had adhered in full. There was no understanding as to why the consultant, Ms Clarkson, was approached so late in the appeal process and in the context of the Appellant providing no evidence from the two previous consultants detailed in the grounds of appeal and in Ms Nash's skeleton argument. No notice had been given to the Respondent, within usual working hours and no steps had been taken to inform the Tribunal more generally of the application. Mr Grey submitted that to admit the evidence would be wrong, unjust and disproportionate, flying in the face of the overriding objective and the statutory function of the CQC. Furthermore, he made the point that Ms Clarkson's evidence appeared to consist largely of opinion. At no point had any notification been provided that the Appellant would seek to rely on opinion evidence for a witness purporting to be an expert. He queried the admissibility of large portions of Ms Clarkson's evidence, given that her expertise must be in question.

12. The Tribunal took time to consider the application and response. The Tribunal applied Rule 15 of the Tribunal Procedure Rules 2008, which provides a wide discretion to admit evidence, even if not admissible in a civil trial in England and Wales and/or evidence which was not available to the previous decision maker. The Tribunal considers the decision to cancel afresh in what is a 'de novo' adjudication. The Tribunal took into account the timeline with this evidence. The Appellant's solicitor acted reasonably in ensuring steps were taken to secure evidence from Ms Clarkson. The Tribunal agreed with the submission from Mr Grey, that fairness had been affected by the level of notice given to the Respondent. In the Tribunal's view, the Appellant could have put the Respondent on notice of the further steps it was taking as soon as 23 October 2023, noting, of course, that the Respondent would not be able to assess its position or provide evidence in response until the evidence was properly served. The Tribunal noted that no reference was made to the further evidence

in the Appellant's skeleton argument, dated 23 October 2023 and the concession made by Ms Nash that the late evidence represented a shift in Mr Adesanmi's position.

13. The Tribunal considered the nature of the evidence – it is of relevance to the decision the Tribunal makes on appeal. As to unfairness, the Tribunal took into account that the witness was available to give oral evidence and answer questions from the Respondent. Furthermore, the Tribunal considered that the unfairness caused by the lack of notification given to the Respondent and the Tribunal could be met by an adjournment. The Tribunal reached it decision with application of the overriding objective. We concluded that the considerations at Rule 2 (a), (b), (c) and (e) were met, which led the Tribunal to decide that the admission of the documents, at such a late stage, was fair, just and proportionate.

14. As a result, the Tribunal adjourned the hearing until 10 am on 31 October 2023 to afford the Respondent time to consider the late evidence and to give the Respondent's witnesses time to reflect on the documents before giving oral evidence.

15. From 31 October to 2 November 2023, the Tribunal heard oral evidence from Mrs Creech, Mrs Winnery, Mrs Mulhall and Mr Adesanmi.

16. On 2 November 2023, Mr Adesanmi was giving sworn evidence to the Tribunal. During his cross examination, he submitted, for the first time in the history of the appeal and during the hearing, that he considered the CQC's inspectors had been unfair, personal and vindictive in their approach to the inspections. In answer to a question from the Judge as to why this position was being mentioned for the first time during cross examination, Mr Adesanmi began to mention discussion with counsel. At that point, Mr Adesanmi was redirected to questions from Mr Grey.

17. Ms Nash requested time to consider her professional position over the lunch adjournment. Mr Adesanmi was released from his oath to clarify his position with his counsel and his solicitor. After some time, Ms Nash withdrew from representing Mr Adesanmi, having considered the Code of Conduct for Barristers. Ms Nash confirmed she had concluded she must withdraw from representing Mr Adesanmi on the ground of professional embarrassment. Subsequent to Ms Nash's withdrawal, Mr Adesanmi spoke directly with his solicitor, who confirmed that the solicitor would also withdraw from representing him in the appeal.

18. The Tribunal explained the options open to Mr Adesanmi and to the Tribunal in the circumstances, which included continuing the hearing. Mr Adesanmi made it clear that he would like time to instruct a new legal representative and he did not wish for the hearing to proceed. Mr Grey did not object to the application to adjourn, making it clear that the Respondent expects the hearing to conclude on the next occasion, noting that the hearing is part-heard.

19. The Tribunal decided to adjourn the hearing, taking into account the need to avoid delay, wherever possible, considering proportionality to the complexity of

the issues in the appeal and the importance of ensuring parties can participate as fully as possible in the proceedings. Mr Adesanmi was informed of the need to act without delay to instruct a new legal representative for the resuming hearing dates, which would be fixed at the forthcoming TCMH.

20. A TCMH took place on 17 November 2023 at which the hearing dates of 10 and 11 January 2024 were fixed. At that stage, Mr Adesanmi had secured new legal representation. Mr Adesanmi confirmed that Ms Clarkson would attend the hearing on 10 and 11 January 2024 to provide oral evidence, based on her previously admitted witness statement. Mr Adesanmi's legal representative, Mr Fitz Okoye from Simon Noble Solicitors, raised a query about applying to admit an updated improvement plan, which had been omitted from the late evidence bundle of 28 October 2023. Mr Okoye and Mr Adesanmi were informed of the need to share the evidence with the Respondent and directed to the Tribunal form to complete to make the application.

21. Mr Adesanmi attended, representing himself on 10 and 11 January 2024. He explained that he was content with the hearing proceeding and he had decided not to use the services of his friend who had helped him at the TCMH (Mr Okoye) due to the costs involved. Mr Adesanmi confirmed at the beginning of the hearing on 10 January 2024 that he did not have any further evidence he wished to apply to admit. In oral evidence, Mr Adesanmi and Ms Clarkson's oral evidence explained that they were not asked by Mr Adesanmi's previously instructed lawyers to provide certain updated documentation. That point is dealt with more fully below.

22. After Mr Adesanmi and Ms Clarkson had completed their oral evidence, Mrs Creech was recalled on specific points which had arisen during Mr Adesanmi's oral evidence and which had not previously been asked of Mrs Creech. The Tribunal regulates its own procedure, subject to the overriding objective and giving effect to the Tribunal Procedure Rules 2008 more generally. Mindful of the fact that the Tribunal is inquisitory in its role, we took the view that it was fair, just and proportionate to the issues in the appeal to permit Mrs Creech's recall to deal specifically with points raised relating to the apparently biased nature of the inspectors and a particular comment which Mr Adesanmi asserted Mrs Creech made during the second inspection in May 2023.

Background

23. The Appellant is currently registered to provide the regulated activity of 'personal care' from one location (as per paragraph 1 above) pending the outcome of this appeal. The Appellant has been registered with the CQC since 8 August 2018. The service provider provides care in the service users' home to a number of service users, some privately funded and some funded by the LA.

24. On 24 November and 2 December 2020, the CQC undertook its first inspection following registration which identified breaches of Regulations 9, 12 and 17 of the 2014 Regulations. The CQC issued requirements notices and rated the service as 'requires improvement' for safe, responsive and well-led. As a

result, on 26 April 2021, the Appellant sent the Respondent an action plan confirming that all breaches had been addressed.

25. On 12 November 2021, the Respondent undertook an inspection which identified breaches of Regulations 9, 12 and 17 of the 2014 Regulations. The CQC rated the service as 'inadequate', with 'inadequate' ratings in the domains of safe and well-led and 'requires improvement' ratings in the domains of effective, caring and responsive.

26. On 19 January 2022, the CQC issued a fixed penalty notice for a failure to notify the CQC of an incident of alleged sexual abuse (between 25 October 2021 and 19 January 2022) under Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009.

27. On 2 March 2022, the Respondent imposed conditions on the Appellant's registration. As part of the conditions on its registration, the Appellant is required, amongst other things, to submit a report to the Respondent on the first working day of each month setting out the outcomes of quality assurance audits. The Appellant is also restricted from taking on new service users' care.

28. The inspection report of 11 January 2022 indicated that the service was in 'special measures' and would be subject to a further inspection no more than 12 months from the date of the previous inspection. The report also indicated that if the service is still rated as 'inadequate' for any key question or overall, the CQC would begin the process of preventing the provider from operating the service, which would usually lead to cancellation of registration or variation of conditions of registration.

29. The Appellant was inspected next on 3 and 10 August 2022 and eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulations') were identified (Regulations 9: person centred care, 10: dignity and respect, 11: need for consent, 12: safe care and treatment, 13: safeguarding service users from abuse and improper treatment, 16: receiving and acting on complaints, 17: good governance and 18: staffing). The service was rated 'inadequate' in all five domains and therefore received an overall rating of 'inadequate'. As a result, a notice of proposal was issued on 26 August 2022, proposing to cancel the Appellant's registration. On 7 September 2022, the Appellant submitted comments as part of the factual accuracy check, which were not accepted. The Appellant provided written representations to the notice of proposal on 27 September 2022. On 28 December 2022, the Respondent issued a notice of decision confirming its proposal to cancel registration.

30. On 24 January 2023, the Appellant filed an appeal to the First-tier Tribunal. The appeal grounds detailed that the decision was not necessary and not proportionate, in light of improvements made with the assistance of two care consultants, Ms Rubina Ali and Care4Quality and the implementation of a new electronic management system, Access Care Planning. The Appellant contended that there had been sustainable improvements to the extent that the Appellant was, as of that date, in compliance with the 2014 Regulations.

31. The Respondent filed its response on 27 February 2023. It considered the decision to cancel registration remains necessary and proportionate in light of the outcome of the inspection from August 2022 and the overall inspection history of the provider, which had been inspected on two occasions prior to August 2022, resulting in ratings of 'requires' improvement' and 'inadequate' and regulatory action taken in the form of requirement notices, a fine and conditions imposed on registration.

32. In preparation for the appeal, the Respondent conducted a further inspection on 5, 10 and 15 May 2023. The inspection covered all five areas or domains – is the service safe, effective, caring, responsive and well-led? The Appellant was rated as 'inadequate' in all domains, apart from caring, which had improved to 'requires improvement'. The overall rating remained as 'inadequate'. The Respondent found that the Appellant continued to be in breach of Regulations 9, 10, 11, 12, 16, 17 and 18 of the 2014 Regulations. There was no longer a breach of Regulation 13, but there was a breach of Regulation 19: fit and proper persons employed.

33. The Respondent took time to review the contents of Ms Clarkson's witness statement and the accompanying documents which were admitted on 30 October 2023. On 31 October 2023, the Respondent confirmed that it did not consider the evidence changed its view that its decision of 28 December 2022 remained proportionate and necessary.

34. Before the hearing resumed on 10 January 2024, the Respondent had sought to secure a transcript of the audio recording of the hearing dates of 30 and 31 October and 1 and 2 November 2023, given that there had been a change in counsel. By the date of the hearing, the recording had not been released to the Respondent's transcribing service. The Tribunal took steps to ascertain a timeline for the provision of transcript to the Judge for review before release to the Respondent. After some enquiries, a timeline could not be provided. Miss Bucklow had helpfully indicated that she did not require the transcripts in order to complete the cross examination of Mr Adesanmi or the remaining oral evidence. However, she would have liked access to them in order to prepare closing submissions. The oral evidence concluded at 4.15 pm on 10 January 2024. The Tribunal updated the parties as to the lack of clarity on a timeline for the transcripts and gave the parties until 11 am the next day to prepare their closing submissions, taking into account that the Respondent had a lawyer attend throughout the hearing to take a note of the proceedings. Miss Bucklow was able to proceed with closing submissions on 11 January 2024. The Tribunal is grateful to both parties for their flexibility.

The legal framework

35. Section 2 of the Health and Social Care Act 2008 ('the 2008 Act') invests in the Respondent registration and review and investigation functions. By virtue of section 3(1) of the 2008 Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.

36. Section 4 of the 2008 Act sets out the matters to which the Respondent must

have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.

37. Section 12 of the 2008 Act obligates the Respondent to grant an application as a service provider where the Respondent is satisfied that the requirements of the Regulations (amongst other things) are being and will continue to be complied with in relation to the regulated activities. If it is not satisfied, it must refuse it.

38. Under section 20 of the 2008 Act, the Secretary of State is empowered to make regulations in relation to the regulated activities by way of regulations. The Regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ('the 2014 Regulations') and The CQC (Registration) Regulations 2009.

39. Sections 26, 27 and 28 of the Act set out the procedural requirements in relation to notification of the Respondent's decision.

40. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to cancel the registration of a service provider in relation to a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect. Under section 32(6), the Tribunal also has power to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates. A 'discretionary condition' means any condition other than a registered manager condition required by section 13(1) of the Act.

41. Part 3 of the Regulations sets out the Fundamental Standards that registered providers must comply with when carrying on a regulated activity, which includes Regulations 9 to 20.

42. The Respondent bears the burden of establishing that it is more likely than not that the 2014 Regulations have not been complied with at the date of the hearing, including 'by having regard to' guidance issued under section 23 of the 2008 Act. The findings of fact are made on the basis of whether or not the Tribunal is satisfied as to the facts on the balance of probabilities.

43. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing. Subject only to relevance and fairness, this can include new information that was not available or presented at the time when the decision under appeal was made. The fresh determination in this appeal includes consideration of the detailed documentary evidence provided by both parties, as well as the oral evidence, subject to questioning over the course of the hearing. We have considered all of the evidence and the written submissions before us, even if we do not mention every point of it in our decision. We refer only to the parts of the evidence which were of particular importance in reaching our findings.

The Parties' Positions

44. The Appellant brought the appeal on the following grounds, which were set out in the grounds of appeal accompanying the appeal application of January 2023, the skeleton argument prepared on the Appellant's behalf in October 2023 and the Appellant's closing arguments.

45. The Appellant contended that:

    (a) He has accepted a significant number of issues (as set out in the Scott Schedule) as issues at the time of the inspections.

    (b) There may have been different outcomes of the inspections if different inspectors had conducted them. Mr Adesanmi considered the approach of the inspectors may have been biased and subjective.

    (c) Even if you take the past breaches of the Regulations and consider them cumulatively, they were not sufficiently serious to mean that the decision to cancel registration was proportionate in August 2022.

    (d) There have been sufficient improvements to the service, which means it is now compliant, namely the introduction of the electronic management system, Access Care Planning and the work of one consultancy firm, Care4Quality and two care consultants, Ms Rubina Ali and Ms Ellie Clarkson.

46. The Respondent defended the appeal on the basis that its decision-making process and the decision subject to appeal have been fair, reasonable and proportionate at each stage. The Respondent relied upon the regulatory history of the service which demonstrated that since its registration it has not been compliant with the Regulations, having never achieved a rating above 'requires improvement'. In its view, the Appellant has been unable to demonstrate that it can make improvements which lead to compliance with the Regulations and demonstrate that such improvements are sustainable without continuing support or at all. Furthermore, it has concerns that Mr Adesanmi (as registered manager and nominated individual) may not have the competence and skills required to ensure sustained compliance with the Regulations and the key domains within a reasonable period of time, given that the Respondent has been unable to assure itself of compliance since the Appellant's first inspection on 24 November 2020.

47. The Respondent's position remains unchanged in light of the follow up inspection it completed in May 2023 and in taking time to consider the documentary evidence from Ms Clarkson.

Evidence

48. The Tribunal had the benefit of signed witness statements from all witnesses called to provide oral evidence. Mrs Creech exhibited all documents provided by the Appellant as part of each relevant inspection. The Tribunal also had

copies of all previous inspection reports since registration in 2018 and the Respondent's 'enforcement decision tree guidance' dated January 2017. The Tribunal had a number of documents from Mr Adesanmi, exhibited to his two witness statements and from Ms Clarkson, exhibited to her witness statement dated 27 October 2023. The oral and documentary evidence is referred to only as it is required to explain our findings and conclusions. The Tribunal noted that the public hearing was recorded and therefore we do not consider it necessary to set out a lengthy summary of the oral evidence.

The Tribunal's conclusions with reasons

49. For the reasons which follow, we uphold the Respondent's decision to cancel the Appellant's registration. Therefore, we have dismissed the appeal.

50. As set out earlier in this decision, Mr Adesanmi had accepted a significant number of the breaches of Regulations identified at the inspection in August 2022 and in some cases continued in May 2023. He confirmed this was his position during his sworn evidence and in the closing submissions he made to the Tribunal.

51. For a number of the factual issues on which the Respondent relied to demonstrate breaches of the Regulations at the points of the August 2022 and/or May 2023 inspections, Mr Adesanmi did not accept there had been failures. The Tribunal made specific findings in relation to the concerns which were said to amount to breaches of the Regulations and which were not accepted by Mr Adesanmi.

52. The Tribunal makes the general observation that Mr Adesanmi accepted, as a general theme, that records and documents were frequently incomplete as they had not been completed as fully as they should have been. At other times during the hearing, when taken to documents in the hearing bundle which he said would demonstrate that something had taken place, it was then discovered that the documents were not the correct ones or that they did not demonstrate that something had or hadn't taken place at the relevant time. The Tribunal found that this was a general pattern of the Appellant's case and how it was presented during the hearing. In the Tribunal's view, this pattern was also relevant to Mr Adesanmi's view of regulation and the inspections. He considered that they were subjective, would have resulted in different outcomes if different inspectors had conducted them and that a lot of the points being raised by the CQC were not major issues, in his view. This was the position he sustained until closing submissions. The Tribunal considered that Mr Adesanmi's evidence was often aimed at minimising the seriousness of the criticisms. It was apparent to the Tribunal that Mr Adesanmi did not accept the seriousness of the breaches, even when viewed cumulatively. He confirmed this during his closing submissions. His main rationale for this was because no service user had ever been harmed. In the Tribunal's view, this demonstrated a limited understanding of the purpose of the CQC inspection framework, which is about assurance. In order for a service provider to assure the CQC, it will have to demonstrate that it has done something or if it hasn't done something, the reasons for its approach or decision and show the CQC where the relevant information is recorded. A further significant issue for Mr Adesanmi, at the time

of the inspections and during the hearing, was that he would frequently contend that something did happen, for example, that a complaint was fully investigated and that a service user was contacted on the telephone to resolve the complaint. However, there was no record provided of the complaint having been recorded and the actions taken having been recorded, including next steps with learning lessons or making improvements, if necessary. This lack of assurance is a pattern, which existed before the inspection of August 2022 and, in the Tribunal's view, persists to this day. In the Tribunal's view, the pattern is indicative of Mr Adesanmi's approach to governance, which is highly relevant to the issue of being able to sustain any improvements and comply with the Regulations, particularly Regulations 12 (safe care and treatment) and 17 (good governance).

53. As an example of this, Mr Adesanmi explained during his oral evidence that he has been 'misled' by his legal representatives and had been led to understand that his evidence should concentrate on the incidents at the times of the inspections. However, the Tribunal did not accept that Mr Adesanmi did not understand the task the Tribunal undertakes on appeal. The Tribunal considers matters afresh and makes a new decision at the time of the hearing. If that wasn't clear to Mr Adesanmi from the inspection report of August 2022 and the notice of decision dated 28 December 2022, then it should have been clear from his grounds of appeal, drafted on his instructions, which set out the steps which had been taken *since* the decision of December 2022. The issue would have been patently clear by the point of reviewing and signing his two witness statements. If it was not clear by that point, then it was certainly clear by the point when he instructed his legal representative to apply to admit late evidence on the first day of the hearing. His legal representative, Ms Nash, made it clear that if the Tribunal decided not to admit the evidence, she had instructions from Mr Adesanmi to apply to adjourn the hearing. The Tribunal has no doubt that Mr Adesanmi understood the task which the Tribunal undertakes on appeal and the importance of documentary evidence which provides assurance that improvements have been made, implemented and sustained, particularly, in a case such as this where Mr Adesanmi accepted the vast majority of concerns from the inspections and accepted that they represented breaches of the Regulations.

Regulation 9(1): the care and treatment of service users must be appropriate, meet their needs and reflect their preferences

54. Mr Adesanmi accepted that the service failed to ensure that complete records were kept for service users at the time of the August 2022 and the May 2023 inspections. However, he did not accept that there was a lack of detailed information about person centred information, such as the service users' preferences. Mrs Creech conducted the review of the records on both occasions and the Tribunal had the benefit of a sample of service users' records from the time of each inspection. The care plans for service users C and D from the time of August 2022 contain no details whatsoever on their personal preferences and their life histories. Mrs Creech confirmed the position in her oral evidence. She considered Mr Adesanmi's explanation that there are times when service users may not wish to provide such information. Mrs Creech acknowledged that there may be times when people are uncomfortable or

unwilling to have those conversations. In that set of circumstances, she would have expected the service provider to make a note of that fact and the conversations which did take place. Her criticism of the records for both service users was that none of the information was recorded in their care plans. In the absence of the information, it is assumed that no discussion took place.

55. By the time of the further inspection in May 2023, Mrs Creech noted that there had been some improvement in the person-centred care relating to service users – as an example, the care plans now recorded some information about the direct family of the service user. However, even with the changes to the care plans, she indicated in her oral evidence that the care plans did not conform with what she would expect from a care plan as there was still no meaningful information about the person to support staff in building a rapport with the person. There was a lack of information about preferences, background information, life history. Having reviewed the records from the May 2023 inspection, the Tribunal noted that each care plan recorded the same details for each service user about what was important to them 'my wellness, respect, dignity, good nutrition'. Mrs Creech confirmed that at the time of the May 2023 inspection, she spoke to staff members. In relation to service user C, one staff member told Mrs Creech that 'I don't know about (SUC) life history, it would be good to have that information. We need to know more about them for a better connection'. Another staff member observed 'would be good to have the history of people as most of the clients talk about memories, it keeps them going'. This captures how important it is to have personalised information about the service users and demonstrates that it was still lacking in May 2023. Accordingly, the Tribunal finds that it is more likely than not that the records did not adequately record personalised information on service users in August 2022 or in May 2023 and that this amounted to a breach of the requirement to provide person-centred care.

    Regulation 13(3): systems and process must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse

56. Mrs Creech explained that the incident which led to the inspection on 3 August 2022 was an incident in July 2022 when service user N's care was provided to them two hours late. The service user had fallen, which was discovered when the team member arrived two hours late. The criticism from Mrs Creech was the lack of record as to any investigation which was carried out, beyond a record of the incident having occurred, which was made on 17 July 2022. It was Mr Adesanmi's position that an investigation had taken place, but no evidence was presented to demonstrate the lines of inquiry of the investigation, its outcome and lessons learnt/areas of improvement. There was also no assurance with regards to steps taken relating to the staff member who had arrived two hours later. Mrs Creech further confirmed that the local authority designated officer (LADO) was not informed of all relevant information about the incident, and it was not clear at all what action had been taken in relation to the staff member.

57. Again, the Tribunal considered that there was a lack of evidence to support Mr Adesanmi's assertion that an investigation had taken place and improvements had been made as a result. He was unable to take the Tribunal to any

documentary evidence to demonstrate that an investigation had been taken forward by the service provider. In that set of circumstances, we concluded that it was more likely than not that no sufficient investigation was completed by the Appellant, and this represented a clear breach of Regulation 13, at which 'abuse' is defined as including neglect of a service user.

Regulation 16(1): any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation

58. With regards to service user D, Mrs Creech had noted that the service user had raised concerns with care in a complaint in March 2022. A spot check was completed by the service, but the service user had submitted another complaint on 12 June 2022 relating to the same concerns. Mrs Creech was critical of the response to the complaint. There was certainly evidence of another spot check and an email sent to the service user on 18 July 2022 asking the service user to call Ms Claire Admans as soon as possible. That was the extent of the evidence. Mrs Creech spoke directly to the service user and their relative and noted the contents of their complaint letter which detailed how the quality of care was impacting greatly and the service user was struggling with their day without reliable support. The Tribunal reviewed a copy of service user D's complaint letter dated 12 June 2022, a detailed, clearly articulated and comprehensive five page typed letter of complaint which set out significant issues with habitual lateness, lack of communication from carers when they are running late, the quality of care relating to preparation of meals, transfers, compression stockings, clothing, application of creams, incontinence pads showering and toileting. The service user also raised concerns about the lack of uniform of a staff member for over one year and a lack of respect, dignity and understanding of service user D's physical disability. The complaints were myriad and serious. Applying the service provider's own complaints policy, there should have been evidence of a record of the complaint in the complaints book, an acknowledgment letter to the person who raised the complaint, any investigation, a written account of the investigation being sent to the service user with the outcomes identified and acted upon.

59. Mr Adesanmi's position was that an investigation was conducted. Again, there was no documentary evidence of what steps were taken, beyond an email dated 18 July 2022 from Ms Admans, attempting to speak to the service user. This demonstrated to the Tribunal that there was no robust oversight of compliance with the service provider's complaint policy and no process appeared to be followed at all in relation to a serious written complaint. The Tribunal concluded that it was more likely than not that service user D's complaint was not properly managed, the complaints policy was not followed, the actions undertaken, and any improvements made could not be evidenced at the point of inspection or in preparation for the appeal hearing and that amounted to a breach of Regulation 16.

Regulation 17(1): systems or processes must be established and operated effectively to ensure compliance with the requirements of assessing, monitoring and improving the quality and safety of services

60. Mrs Creech identified a number of areas of concern at both inspections in relation to this Regulation, more commonly referred to as good governance. Mr Adesanmi accepted a number of failures on behalf of the service provider. However, he disputed eight areas of concern. Firstly, he did not accept that the Appellant failed to ensure there were effective systems in place to quality assure care at inspections in August 2022 and May 2023. Mr Adesanmi advanced the argument that care plans were reviewed but accepted that the systems in place were not completely effective. As an example of this, Mrs Creech pointed to the condition of registration which had been imposed on 2 March 2022. The service provider was required to send the Respondent monthly audits of care plans, daily care notes, MAR charts, staff training and competencies, complaints, accidents and incidents. Mrs Creech explained that at the point of inspection in August 2022 and the point of inspection in May 2023, the documentation available at the service provider did not accurately reflect what she found. For example, service user D submitted a complaint in March 2022. The service provider sent a report to the Respondent for that month which made no reference to the complaint's existence. The report took a superficial approach, setting out that audits of care plans had taken place, but there was no evidence that the outcomes of the audit had been followed up to ensure the shortfalls were remedied. As a further example, in March 2022, the audit found that there was no evidence of power of attorney in relation to service user K and that a particular staff member was to action the omission as a matter of urgency. There was then no evidence available that this issue has been rectified. It appeared in audit reports for April, May and June 2022, with no evidence to demonstrate it had been addressed. The Tribunal concluded that the audit reports did not reflect the position of the service provider's work to come i and therefore did not provide the necessary assurance to the Respondent that the Appellant was making and embedding improvements in order to demonstrate effective governance and compliance with Regulation 17.

61. Mr Adesanmi did not accept that service user J's Saturday home call was missed on any occasion and what had actually occurred was that service user J's relative had cancelled the call due to a lateness issue with the staff member. The difficulty with Mr Adesanmi's position is that there is no record to assist the Tribunal as to what happened at the time in question. Mrs Creech provided evidence from the inspection, which demonstrated that on 24 March 2022, as part of a quality monitoring discussion, service user J's daughter had rated the service as 6/10 and explained that on some Saturdays, people had not turned up. If there was evidence before the Tribunal of an investigation of some kind having been carried out, to assist the Tribunal with understanding the arrangements with service user J's home calls and what failures, if any, were found, this would have assisted the Tribunal with having confidence in Mr Adesanmi's explanation of the issue. However, in the absence of evidence to support his explanation, the Tribunal concluded that it considered it was more likely than not that service user J was not always receiving home calls on Saturdays and there was a failure to have a robust system in place, at that time, to manage governance of effective home calls.

62. Mrs Creech was clear in her oral evidence, witness statement and in the inspection report from August 2022 that during the inspection, she was informed that a staff member had been suspended pending an investigation in

relation to arriving two hours late to a home call for service user N, who had fallen at some point before the carer eventually arrived. Mr Adesanmi was clear that Mrs Creech was mistaken, in that he did not inform her that the staff member had been suspended. Mrs Creech was clear that she was informed that the staff member had been suspended and it was only when she saw the staff members' name on the two previous rotas dated 18 July 2022 and 3 August 2022, that she was then informed that the staff member was not suspended and that had been a miscommunication. The Tribunal found that it was more likely than not that Mrs Creech was informed that the staff member had been suspended. At the time in question, as accepted by Mr Adesanmi, the service was in breach of good governance and was not at the standard that it should have been. There was a lack of acceptable record keeping and detailing on what was and what was not in place and, crucially, what steps were being taken in relation to complaints handling, including investigation. In the context of an inadequate level of record keeping and a failure to follow the complaints policy, as well as Mrs Creech being clear that this was communicated to her and then corrected when she saw the staff member's name appearing on the rota, the Tribunal considers that inaccurate information was shared with Mrs Creech. Furthermore, the Tribunal has concluded that the inaccurate information supports an inference that the service provider was not acting transparently at that time, not least as its systems and records were not able to provide assurance as even on the Appellant's own account, they were not complete and therefore not effective.

63. Service user D's complaint of June 2022, as detailed above, was explained as a matter of personal preference. The Tribunal read the complaint letter, which is lengthy and detailed. There is no evidence that it was ever subject to an investigation, perhaps because it was perceived, wrongly, in the Tribunal's view, on any common sense reading of it, as a matter of personal preference. As a result of this wrong perception of the complaint, no action was taken at all. The Tribunal concluded that the failure to review the complaint letter and demonstrate that action was taken amounted to a failure to ensure effective systems were in place to take steps to improve the service, which is. A breach of the good governance Regulation.

64. The Tribunal considered the survey document from 2021, which indicated that the service provider would put in place an action plan for a number of areas of improvement. The Tribunal saw no documentary evidence to demonstrate how the action plan had been implemented and what the results were, following a review of the actions – for example, had they been completed or if not completed, why not? Furthermore, it is of significance to note that despite the identification of the need for an action plan at the end of 2021, by the time of the August 2022 inspection, not only was there not documentary evidence of an action plan being implemented, but Mrs Creech continued to find failures with governance – failures which arguably would not have been a as significant or in existence if an effective action plan had been implemented and followed with frequent reviews.

65. Staff reported that they were not provided with an opportunity to give their feedback. The Tribunal was not taken to any evidence which demonstrated

that staff's views were sought and what action was taken as a result. Accordingly, the Tribunal has found this matter proved.

Regulation 18(1): sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the regulatory requirements

66. As previously detailed, service user C provided a detailed letter dated 12 June 2022 in which they raised complaint about times when there was one staff member in attendance, despite the need for two, as set out in their care plan, which confirmed that service user C required two carers to be in attendance for getting into and out of bed and chairs by using a hoist. Mr Adesanmi contended that two staff members always attended. Perhaps if there had been any documentary evidence to demonstrate that a fact-finding process or investigation of any kind had been completed, this explanation may have been accepted. However, in the absence of any contemporaneous documents or records, the Tribunal finds that it was more likely than not that there were occasions when service user C was not attended by two staff members. The Appellant's system for recording staff attendance at calls, at that time (2023) was not reliable, not least as there were numerous occasions, on Mr Adesanmi's own evidence, when staff had difficulties with logging in on the system when they arrived and/or left a home call. Furthermore, Mrs Creech explained that service user C's concerns were corroborated by their relative in the expert by experience call, which set out that about once a week only one carer would turn up on the call. Mrs Creech also reviewed evidence that on 9 July 2022, less than one month after service user C wrote their letter of complaint, a healthcare professional had raised the concern with the service provider directly. Again, in the absence of any evidence demonstrating that an investigation took place and what the investigation established, the Tribunal considers sufficient evidence has been provided to allow it to conclude that it was more probable than not that service user C's care was not always being adequately provided by two carers and this amounts to a breach of Regulation 18.

Regulation 19(2): recruitment procedures must be established and updated effectively to ensure that persons employed meet the conditions of good character, qualifications, competence, skills and health (after reasonable adjustments have been made)

67. This Regulation was found to be in breach by the Respondent for the first time as a result of the inspection in May 2023. Mrs Creech criticised three specific instances. Firstly, the Appellant was unable to assure through evidence that it had conducted a check of staff member 13'sreferencee. In the hearing bundle, the Tribunal had the benefit of reviewing the undated typed reference provided for the staff member. Mr Adesanmi explained that a check did take place. He was able to provide written records of checks on two references for staff member 14, but no evidence was provided to assure the Respondent at the time or the Tribunal since that the check took place. On balance, the Tribunal considered that it was more likely than not that no check took place as there was no record of it.

68. Secondly, Mrs Creech criticised the lack of checks on the references for staff member 14. Mr Adesanmi explained that the two written records in the hearing bundle demonstrated that managers at both previous positions were contacted in order to verify their references for the staff member. The Tribunal concluded that the records were sufficient to demonstrate that checks had taken place and the service provider had made adequate records of the verification process and content. Accordingly, the Tribunal did not conclude that there had been a breach of Regulation 19 in relation to staff members 14's reference checks.

69. Thirdly, there was no evidence available that the service provider had undertaken appropriate checks, in particular a Disclosure and Barring Service (DBS) check in relation to a person who was working with Ms Ali. This person was conducting audits at the service provider in 2023, which included entering servicer users' homes. There was no evidence to assure the Respondent that Mr Adesanmi or the service provider had conducted checks. Mr Adesanmi explained that he was shown the DBS certificate for this person, but the criticism remained that there was no record retained to demonstrate that the check had taken place, including a screenshot/photograph of the relevant DBS certificate. In the absence of any documentation to assure the Tribunal that such a check had taken place, the Tribunal has drawn the inference that it did not. Accordingly, this is found proved.

70. In turn, the Tribunal considered Regulation 19. The Tribunal found that the failures in respect of Ms Ali's colleague and staff member 13 amounted to breaches of Regulation 19(2).

Grounds (a) and (b)

71. As set out at paragraph 45 above, Mr Adesanmi submitted that he had accepted a large number of the issues at the time of the inspections and had sought to make improvements. However, he also contended that the inspectors may have been biased and subjective. Mr Adesanmi told the Tribunal, for the first time in oral evidence, that Mrs Creech had made an inappropriate comment about the fact that he would no longer be able to fly first class to Nigeria, presumably as a result of the outcome of the inspection. To Mr Adesanmi, this demonstrated that Mrs Creech was approaching the act of inspection in a subjective way and it was an unprofessional comment to make. Mrs Creech was recalled to deal with this point. She did not accept that she had made any comment about Mr Adesanmi flying first class, let alone a comment that it would not happen again. Mrs Creech explained that she recalled discussions with Mr Adesanmi about the fact that he initially planned to be away on the date when the inspection took place but had rearranged his travel to be present in May 2023. She contended that it was Mr Adesanmi who made the unsolicited comment that he travelled first class. Furthermore, she did not accept that she had been 'digging for negative issues'. Mrs Creech explained that she attended three separate inspections of the service provider, speaking to multiple members of staff. She observed that staff were more relaxed around her and the inspectors when Mr Adesanmi was not present. Mrs Creech was clear that she had not made the comments Mr Adesanmi attributed to her and that she has not approached the inspections in a biased or prejudged way.

72. The Tribunal considered the oral evidence from both witnesses. There was not documentary evidence to support this incident. Mr Adesanmi had not previously set it out in his two witness statements and Mrs Creech had not been asked questions about this issue when cross examined by Mr Adesanmi's counsel, Ms Nash. The Tribunal found Mrs Creech to be a credible and reasonable witness. She gave oral evidence for a significant period of time during the hearing, as to be expected given that she had been an inspector at three separate inspections of the service provider. Her evidence was, in the Tribunal's views, balanced and fair. She did not present as a witness who came to the process of inspection with bias and having prejudged the service provider. There was no evidence to support this assertion, made for the first time during the hearing. The Tribunal took into account the correspondence from the Respondent, including its inspection reports and its letter of notification to the service provider, which provide the details if the recipient wished to make a complaint about staff members form the Respondent. Mr Adesanmi was engaged in the inspection process, to the extent that, for example, before the inspection report of August 2022 was published, he provided representations on accuracy and he provided representations in response to the notice of proposal. In the Tribunal's view, if Mr Adesanmi had concerns about the question of bias or prejudgment, it would have been highly likely that the concerns would feature as part of the written representations at the factual accuracy and the notice of proposal stages. Furthermore, upon bringing the appeal, it would have been highly likely that such a serious assertion would have formed the foundation of the grounds of appeal and featured in the written submissions to the Tribunal. However, the assertion of bias was absent. The Tribunal found that there was no credible evidence to support it reaching the rational conclusion that the inspections were approached in a biased and subjective manner which was material to the value and weight the Tribunal could attach to the outcomes of the inspections. The Tribunal considered carefully the evidence as to the Respondent's methodology for inspections, as well as its enforcement decision making guidance. The Tribunal found that the Respondent's inspectors approached their role with care, taking an evidence-based approach to the Regulations and to the question of risk.

73. As to the assertion that Mrs Creech had made unprofessional comments regarding Mr Adesanmi travelling first class and not being able to do that in the future. The Tribunal concluded that there was insufficient evidence to find that this happened. In fact, the Tribunal found that this comment was not made. The Tribunal considered Mrs Creech to be credible. She showed genuine surprise when these comments were raised with her. The Tribunal had no difficulty in concluding that this was because it was the first time she had heard this assertion. Furthermore, the Tribunal considers it highly relevant that no previous concern or complaint was raised by Mr Adesanmi about this apparent comment. The Tribunal drew the inference, when considering this evidence in the round, that Mrs Creech did not make the comment. The Tribunal had no doubt that if she had made such a comment, there would have been a reference to this issue at an earlier point than during oral evidence at the hearing. Accordingly, the Tribunal does not consider, on a balance of probabilities that Mrs Creech made the comment or that the inspectors approached their roles in a biased or subjective manner.

Ground (c): even if you take the past breaches of the Regulations and consider them cumulatively, they were not sufficiently serious to mean that the decision to cancel registration was proportionate in August 2022

74. At each inspection, a sample of the records from service users were reviewed by the inspectors, a sample of staff provided input to the inspectors and an expert by experience contacted service users and their relatives to seek feedback. The Tribunal considered the sample to be wide enough and the sources of information diverse enough to mean that the findings of the inspectors were made on a sufficiently robust review of the care provided by the Appellant. By the time of the inspection in August 2022, the service provider had been in breach of the Regulations concerning person centred care, safe care and treatment and good governance since registration. It was also significant to note that regulatory enforcement action had previously been taken by the Respondent. By the time of August 2022, when the Respondent found the Appellant to be in breach of eight of the fourteen fundamental standards of Regulations, the Appellant had been subject to a number of enforcement decisions. The Respondent and the First-tier Tribunal on appeal is entitled to take into account the regulatory history of the service concerned. Section 17(1)(c) of the Health and Social Care Act 2008 sets this out. The Tribunal noted that at the time the decision was taken to cancel the registration of the service provider for the regulated activity of personal care, the Appellant had not been in compliance with Regulations 9, 12 and 17 at either of the previous two inspections. The Appellant had received requirement notices which required improvement through an action plan, a fixed penalty notice relating to a failure to disclose an allegation of abuse or neglect, conditions had been imposed on the Appellant's registration which restricted the Appellant from taking on new service users and required the Appellant to provide quality assurance audits to the Respondent every month. By the time of the inspection in August 2022, the Appellant was found to be in breach of additional Regulations than from the previous inspection, at which the enforcement outcome was conditions. It was significant evidence, from the witness statements and oral evidence of Mrs Creech and Ms Mulhall, that in spite of a condition, from 2 March 2022, to provide evidence of quality assurance audits and action taken as an outcome of the audits, the Appellant was in breach of an additional five Regulations at the next inspection on 3 August 2022. From the Tribunal's assessment of the evidence, the regulatory position, by the point of 3 August 2022, had declined. The Appellant was entitled, when reviewing its enforcement decision tree guidance (January 2017) to infer that even with conditions placing an onus on the service provider to demonstrate that audits were taking place and improvements were being made, the Appellant's regulatory compliance had worsened in a matter of five months. The Tribunal paid regard to the Respondent's enforcement decision tree guidance and noted the following relevant points:

- The Respondent takes progressively stronger action in proportion to the seriousness of the breach and the potential impact on people using a service as well as the number of people affected. Similarly, the Respondent will take stronger action where a service is carried on in an inappropriate way without effective management of risk.

- Inspectors should use their assessment or the potential impact of the breach and the likelihood that the facts giving rise to the breach will happen again to assess the seriousness of the breach.
- In the Appellant's case, by August 2022, the seriousness of the breaches was assessed as level 'high'. Before making a recommendation, inspectors should consider whether or more or less serous level of enforcement than the initial recommendation is appropriate. As part of this assessment, the inspector should consider whether the identified breach and conduct is part of a pattern demonstrating systemic failings.
- The service provider's ability to identify risks and make and sustain necessary improvements should be assessed.

75. By the time of the August 2022 inspection, the Appellant had been under conditions which required it to carry out audits and make improvements. The breaches were greater than at the previous inspection. The regulatory history was one of no higher a rating at any point since registration than 'requires improvement'. At the time of the inspection in August 2022, the service was rated as 'inadequate' and had been rated as such since November 2021. Mrs Mulhall and Mrs Creech's evidence as to the approach to decision making as a result of the August 2022, led to an assessment of 'high'. The decision to discount conditions was based on the fact that conditions had been in place since November 2021 and the service had not managed to improve. Mrs Mulhall explained that suspension was not considered a proportionate response as the issues concerned safeguarding, safety and leadership.

76. By the time of the August 2022 inspection, notable incidents of failings had been identified. They include but are not limited to a lack of records to demonstrate that complaints were being dealt with in line with the Appellant's complaint handling policy, a lack of records to demonstrate that staff had conducted care reviews in light of a change in a service user's condition. For example, service user A's deteriorating condition was noted over four days in June 2022. On the fourth day, the GP was called, although there was no record of the outcome of the discussion with the GP. Service user A was admitted to hospital for four weeks and upon discharge, their mobility had decreased and they were using a frame for walking support. Mrs Creech reviewed the care plans for service user A which still referred to service user A using a walking stick, with no reference to the time in hospital or changes to the care required as a result.

77. Mrs Creech reviewed a five-page letter dated 12 June 2022 from service user D, setting out in careful detail a number of complaints, relating to care over a ten-week period, with specific dates included of a number of incidents. Issues included: staff were arriving late on a consistent basis by 50 minutes or more for the breakfast calls, no updates were received when staff were running late, unsafe transfers, the quality of care had not improved, despite a previous discussion with Mr Adesanmi about the issues in December 2021 and March 2022, and issues with staff's attitude, including towards physical disability. There was no evidence that the complaint had been addressed at all.

78. These are just two examples, which when taken with the Appellant's regulatory history and lack of compliance and in applying the Respondent's approach to

responses to risk, demonstrated to the Tribunal that the action taken in August 2022, in deciding that it was proportionate and reasonable to issue a notice of proposal to cancel was a decision that was within the range of appropriate responses to the ongoing issues at the service provider.

Ground (d): there have been sufficient improvements to the service, which means it is now compliant, namely the introduction of the electronic management system, Access Care Planning and the work of one consultancy firm, Care4Quality and two care consultants, Ms Rubina Ali and Ms Ellie Clarkson

79. This was the foundation of Mr Adesanmi's appeal. He has accepted a significant number of failures at the service provider from the two inspections in August 2022 and May 2023. The Tribunal kept in mind that it makes the decision as at the date of the hearing and it is entitled to take into account and carefully assess the evidence as to improvements made to the service provider since the point at which the Respondent made its decision to cancel registration.

80. The Tribunal noted that by the time of the most recent inspection, once the appeal had been made to the First-tier Tribunal, Mr Adesanmi remained in breach of eight Regulations and the rating remained as 'inadequate'. The Tribunal had concerns about this outcome. At that point, Mr Adesanmi had used the services of an external consultancy company. The Tribunal accepted his explanation for not to continuing to use the service due to the costs involved. However, from November 2022 onwards, Mr Adesanmi had used the service of Ms Rubina Ali as a care consultant. On his own evidence, by the point of February 2023, he had concerns about Ms Ali's level of commitment and ability to do the job he required from her. However, despite that, Mr Adesanmi continued to use Ms Ali's services. After the May 2023 inspection and outcome, Mr Adesanmi still continued to use the services of Ms Ali and explained that he retained her services until October 2023 when he met with Ms Clarkson and engaged her services as of 7 October 2023. The Tribunal found Mr Adesanmi's judgment to be of great concern.

81. As an example of an issue which persisted (safe and effective care), service user K had been discharged from the NHS Speech and Language Therapy (SaLT) Adult Service on 18 October 2022 with a detailed discharge report, which noted that service user K was now at risk of aspiration and choking from their oral intake. Service user K's care plan was unchanged, despite the information in their SaLT discharge report. In fact, the care plan still made reference to the service user receiving cups of tea and biscuits at ever visit, despite the report of 18 October 2022 implementing a plan for eating and drinking with minced and moist diet and slightly thick fluids due to the risk of aspiration. There was also a requirement for advanced care planning to be discussed and clearly documented. Again, there was no evidence to demonstrate this had been completed. There was a clear risk of harm to service user K.

82. The Tribunal considered the contents of Ms Clarkson's witness statement carefully. It did not have the benefit of a witness statement from Ms Ali and this

was relevant as Ms Clarkson had started working for the service on 7 October 2023. By the time of the first hearing, Ms Clarkson had provided a witness statement dated 27 October 2023. Ms Clarkson explained, at that point, that she considered it would take six months for the service to come into compliance. This was a significant statement as it demonstrated to the Tribunal that Ms Clarkson, who undoubtedly had, on her own detailed account, substantial experience of supporting services to improve, had made her own assessment of the Appellant and concluded that as of 27 October 2023, just before the hearing started, the service was not yet in compliance and that process would take approximately six months.

83. The Tribunal considered a number of documentary exhibits to Ms Clarkson's witness statement. They consisted of updated forms, information about conditions such as vascular dementia, an update care plan and a number of documents relating to risk assessments, medication recording and a service improvement plan. The documents were blank or in template form and did not provide the Tribunal with an understanding of how the service was utilising them, in practice. As an example, the Tribunal had sight of 'guidance on what is required before an MCA (Mental Capacity Act 2005) assessment is carried out'. This set out the principles to think about in approaching an assessment but did not provide assurance to the Tribunal that the previously identified deficiencies with assessing capacity and staff's knowledge of capacity and best interests decision making had been met with further training, with audits of the records, or by reviewing the record keeping in practice at the service since the last inspection in May 2023. This would have been valuable evidence to the Tribunal as it would have helped it in assessing the extent to which improvements had been made and were embedded in the service. The absence of that information led the Tribunal to conclude that on balance, the service provider has been unable to demonstrate the significant improvement and sustained improved practice which would be required to establish that the decision to cancel its registration, as at the date of the hearing, was no longer a proportionate or reasonable decision.

84. Ms Clarkson was a sincere and committed witness, who clearly wished to support Mr Adesanmi to improve the service. The Tribunal had little doubt that Mr Adesanmi wishes to continue working in the care sector, providing a service to which he has devoted a large part of his professional life. However, commitment and dedication is not sufficient to assure the Tribunal that wide ranging improvements have been made and improved practice can be sustained with the service being able to demonstrate compliance with all of the fundamental standards of effective, competent and safe care, governance and leadership.

Conditional registration: a proportionate response at this stage?

85. Mr Adesanmi did not specifically address the Tribunal on this point, leaving it to the Tribunal as to whether it considered conditions continued to be necessary or proportionate. Mr Adesanmi's primary submission was that if the service was inspected as of the date of the hearing, it would be found to be in full compliance with the Regulations. The Respondent's position on this point was clear, in light of the sustained nature of the breaches of the Regulations, couple

with the overall regulatory history and in considering Ms Clarkson's recent evidence of remediation, the Respondent was not satisfied that there are any conditions which are practical, workable and proportionate to the level of risk posed to members of the public.

Order

It is ordered that:

The appeal is dismissed.

Judge S Brownlee

Care Standards & Primary Health Lists Tribunal

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

Date issued: 30 January 2024